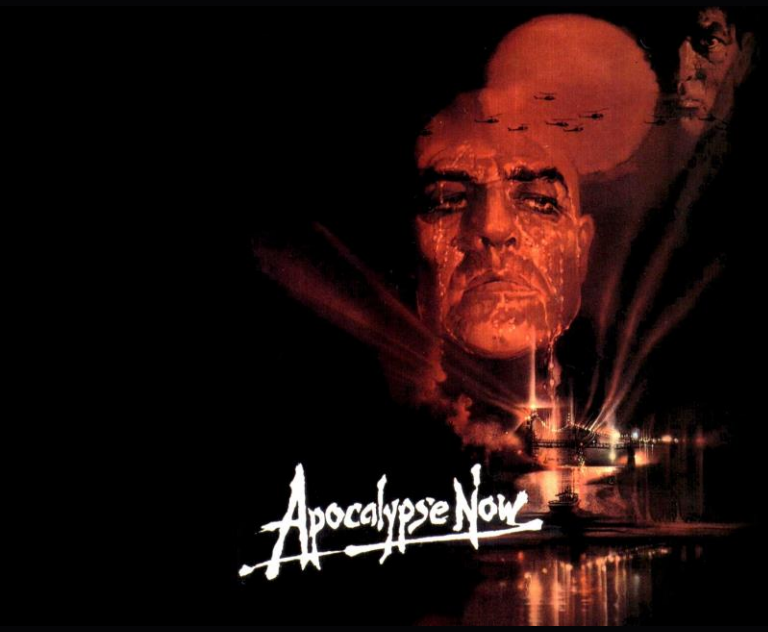
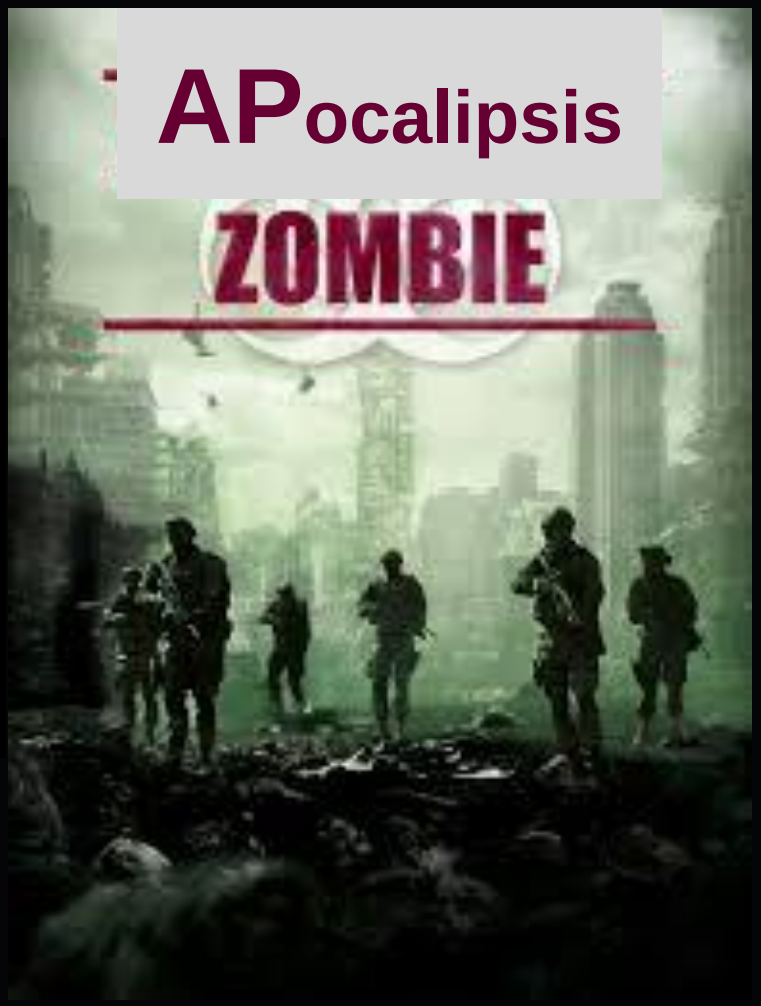

Cuando todo se tambalea
Jornada sobre la Atención Primaria de salud
Bilbao 24/05/25
Ponencias
Luis Palomo Cobos
Especialista en MFyC y diplomado en SaludPública, en Metodología de la Investigación y en Bioestadística
Susana Martín Benavides
Especialista en MFyC, primera Subdirectora para la Coordinación de la Atención Primaria de Euskadi
Sergio Minué Lorenzo
Especialista en MFyC, doctor en economía, profesor Escuela andaluza de Salud Pública
Entrada libre hasta completar el aforo
OSALDE
OSASUN ESKUBIDEAREN ALDEKO ELKARTEA
ASOCIACIÓN POR EL DERECHO A LA SALUD
hika ateneo
Eskola Zumarkalea, 1, Ibaiondo,
48006 Bilbao, Bizkaia

Cuando todo se tambalea





¿Está en crisis el actual modelo sanitario del Sistema Público de Salud?

¿Nuestro modelo sanitario se basa en la atención primaria?

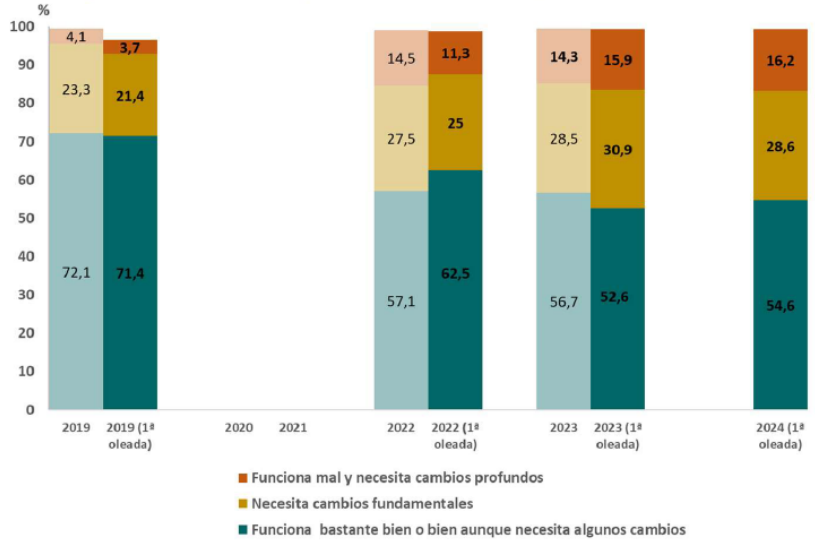
La crisis de la AP: cómo este nivel de atención acaba colapsando

¿Qué cambios son necesarios?

Satisfacción

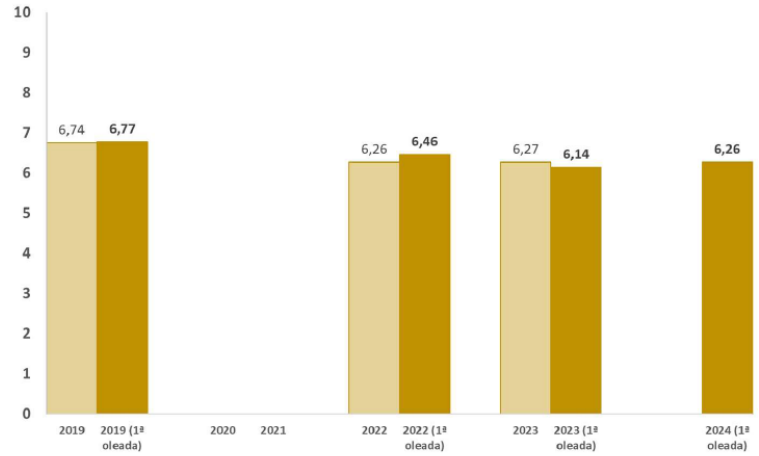
Gráfica 1. Valoración del funcionamiento del sistema sanitario. Evolución 2015-2024. Total y primera o
cada año

Población general de 18+ años (1ª oleada 2024 n=2576)



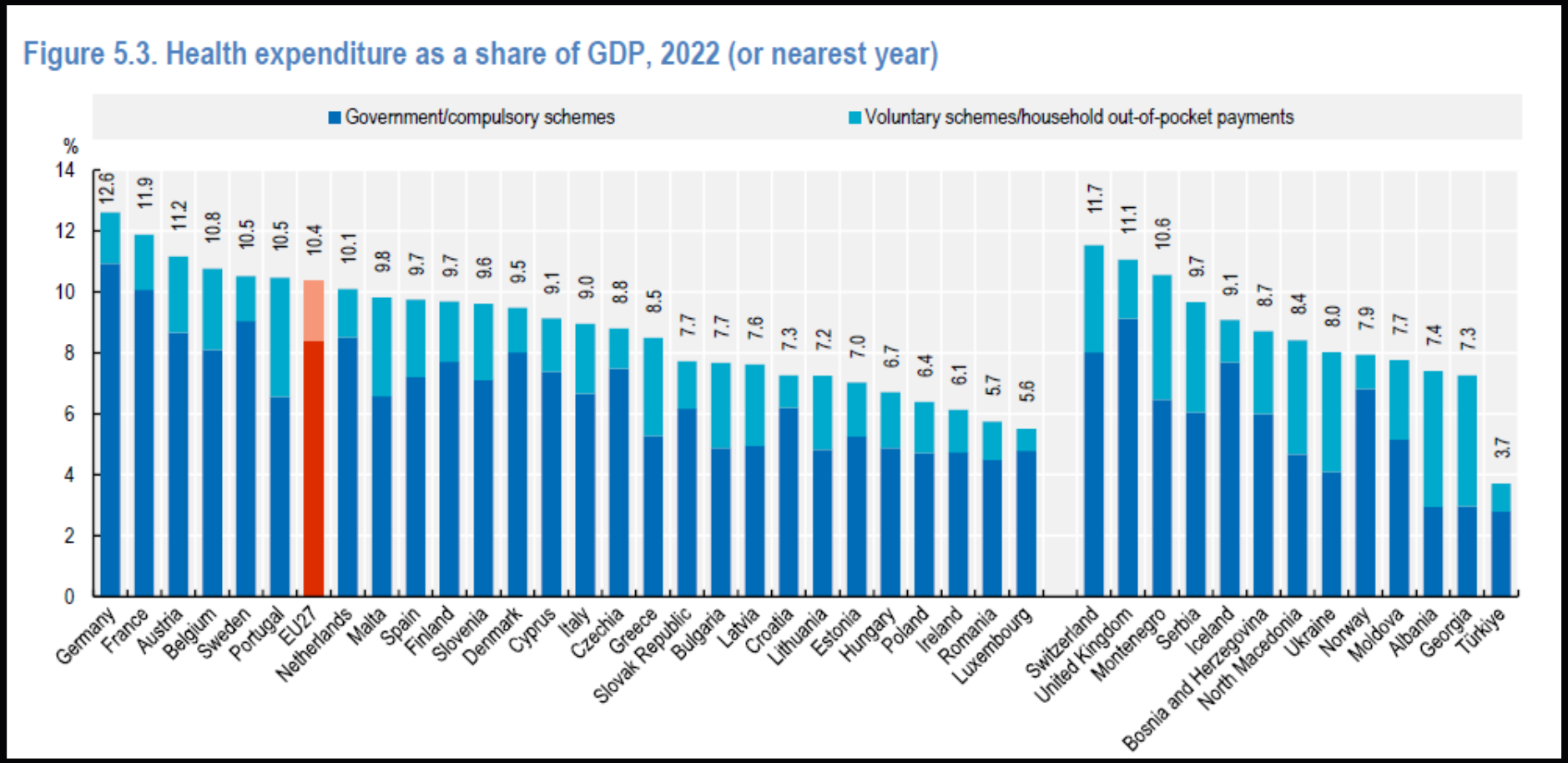
Gráfica 2. Satisfacción con el funcionamiento del sistema sanitario público. Evolución 2015-2024. Total y primera
oleada de cada año

Población general de 18+ años (1ª oleada 2024 n=2576)



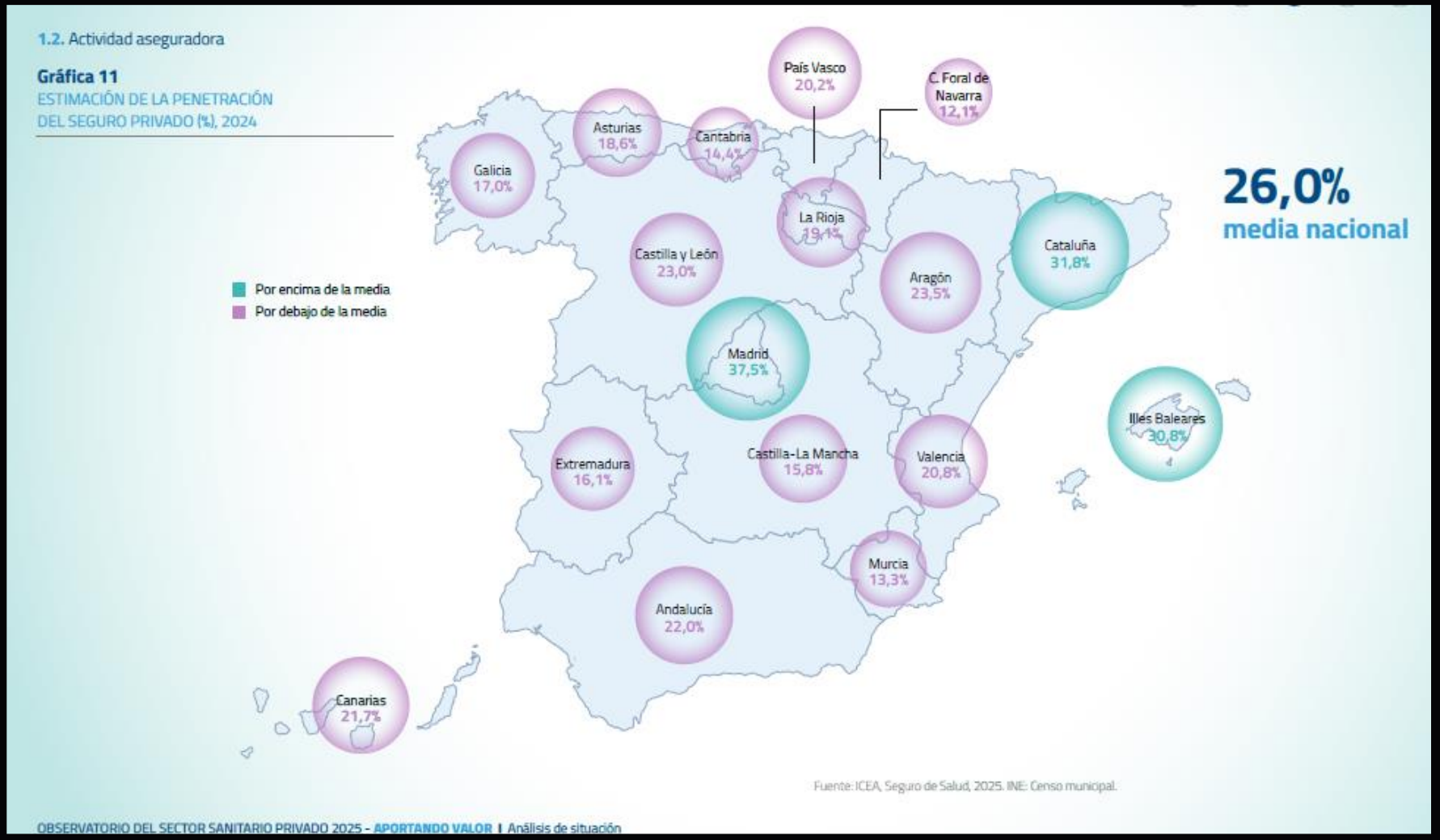
Barómetro sanitario 2024

La distribución del gasto



OCDE 2024

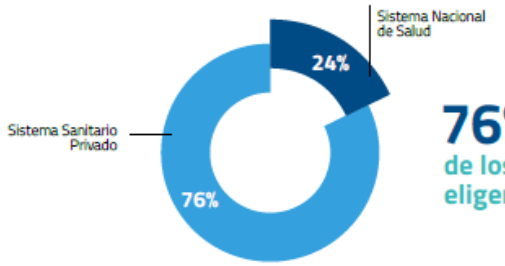
El crecimiento del sector privado



La “solución” a MUFACE

Gráfica 13

ELECCIÓN DE ASISTENCIA DEL FUNCIONARIADO, 2024



76%
de los funcionarios eligen sanidad privada

Fuente: Elaboración propia a partir de los datos de ICEA Seguro de Salud 2025 y memorias de las mutualidades 2023

Tabla 1

COMPAÑÍAS ASEGURADORAS QUE MANTIENEN CONCIERTO CON LAS MUTUALIDADES, 2022-2024

	ASISA	DKV	SEGURCAIXA ADESLAS	MAPFRE	NUEVA MUTUA SANITARIA	SANITAS
MUFACE	✓	✓	✓	-	-	-
ISFAS	✓	-	✓	-	-	-
MUGEJU	✓	✓	✓	✓	✓	✓

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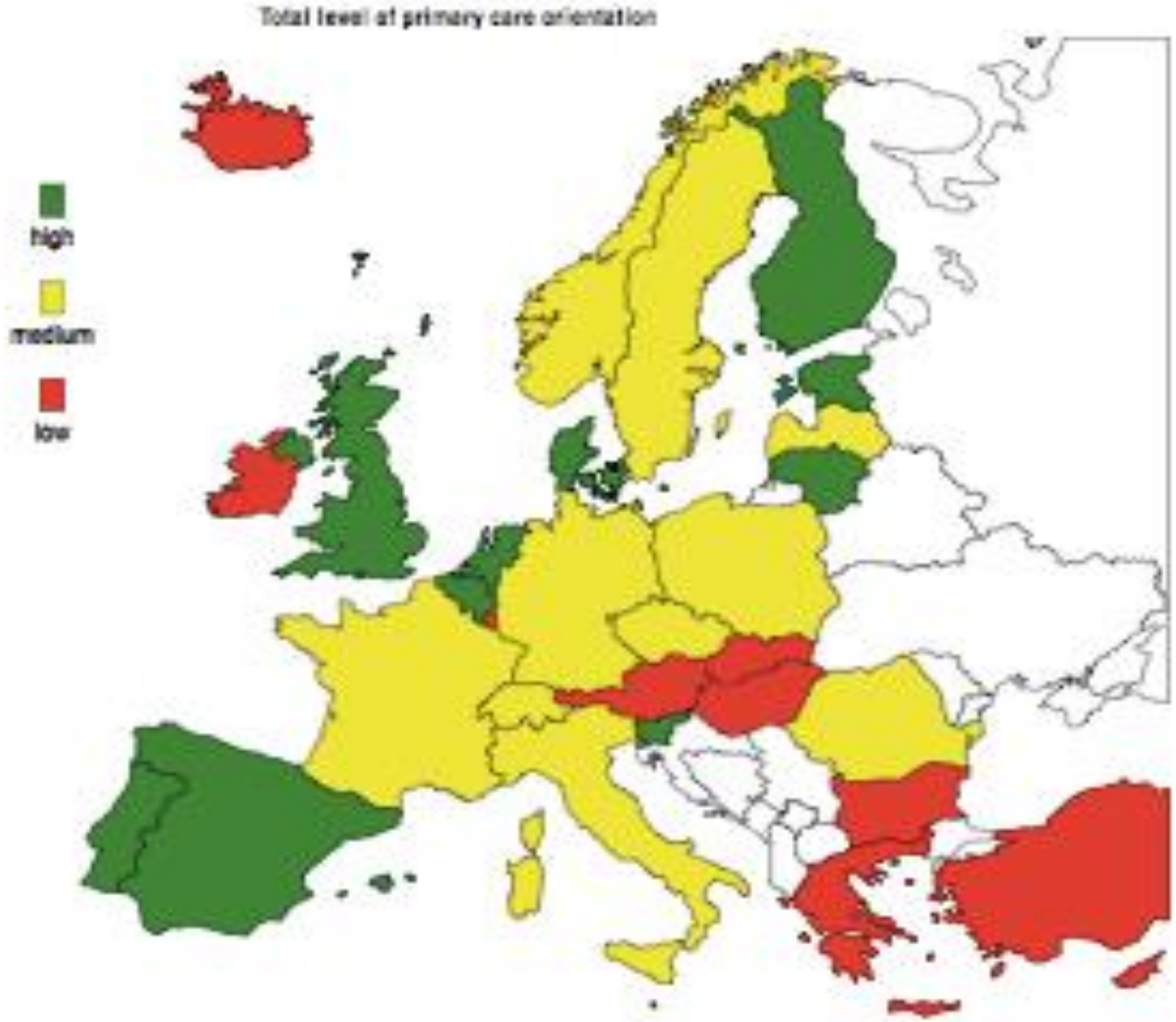
La crisis de la AP: cómo este nivel de atención acaba colapsando

¿Qué cambios son necesarios?

Variation in the overall strength of primary care in Europe

Kringos et al, 2015



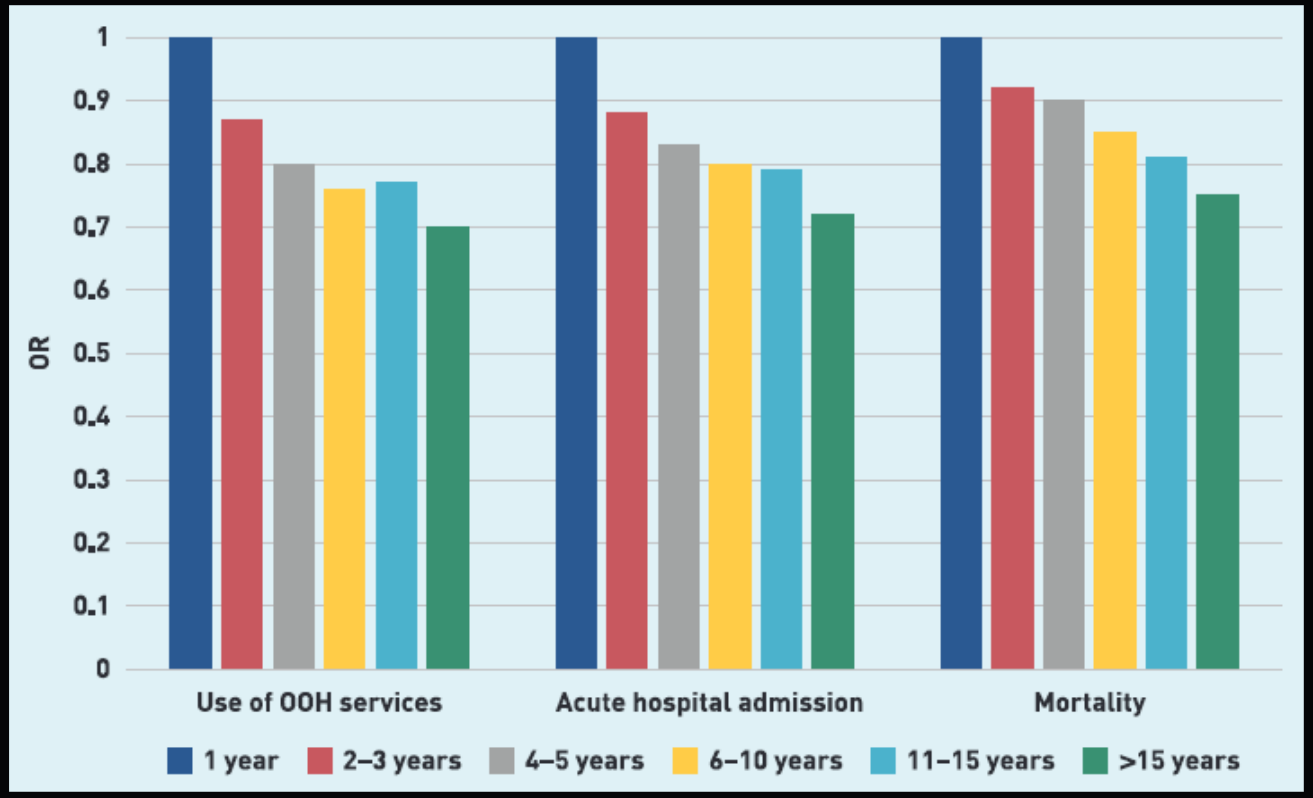
Media días de espera para que la cita sea atendida en atención primaria por año y CCAA				
CCAA	2018	2019	2022	2023
Andalucía	3,8	5,6	9,6	10,4
Aragón	3,3	3,5	7,5	7,6
Asturias	3,3	3,7	5,6	4,9
Cantabria	3,9	4,9	6,5	6,3
Castilla y León	3,2	3,2	5,6	5,8
Castilla-La Mancha	3,5	3,9	6,4	8,3
Canarias	4,1	5,4	9,7	8
Cataluña	7,5	8,9	11,6	12,1
Extremadura	3,7	4,1	6,6	6,6
Galicia	2,8	4	6	6,7
Islas Baleares	4,7	5,5	9,3	7,9
Murcia	4,4	5,3	8,5	6,5
Comunidad de Madrid	3,6	3,8	9	9,6
Navarra	3,4	3,8	7,1	5,6
País Vasco	3,6	3	5,3	5,7
La Rioja	3,2	2,6	7,6	6,8
Comunidad Valenciana	4,5	6,4	10	9,8

Mantener el mismo médico de APS más de 15 años reduce la mortalidad hasta un 30%

Research

Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care:

a registry-based observational study in Norway



ORIGINAL RESEAR

General practitioners retiring or relocating and its association with healthcare use and mortality: a cohort study using Norwegian national data

Kristin Hestmann Vinjerui ,[1] Andreas Ashelm ,[2,3] Kjartan Sarheim Anthun,[4] Fredrik Carlsen,[5] Bente Prytz Mjølstad,[6] Sara Marie Nilsen,[2,7] Kristine Pape,[1] Johan Håkon Bjørngaard[1,8]

► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/bmjqs-2023-017064).

For numbered affiliations see end of article.

Correspondence to
Dr Kristin Hestmann Vinjerui; kristin.vinjerui@ntnu.no

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ABSTRACT

Background Continuity in the general practitioner (GP)-patient relationship is associated with better healthcare outcomes. However, few studies have examined the impact of permanent discontinuities on all listed patients when a GP retires or relocates.

Aim To investigate changes in the Norwegian population's overall healthcare use and mortality after discontinuity due to Regular GPs retiring or relocating.

Methods Linking national registers, we compared days with healthcare use and mortality for matched individuals affiliated with Regular GPs who retired or relocated versus continued. We included list patients 3 years prior to exposure and followed them up to 5 years after. We assessed changes over time employing a difference-in-differences design with Poisson regression.

Results From 2011 to 2020, we identified 819 Regular GPs retiring and 228 moving, affiliated with 1 165 295 people. Relative to 3 years before discontinuity, the rate ratio (RR) of daytime GP contacts, increased 3% (95% CI 2 to 4) in year 1 after discontinuity, corresponding to 148 (95% CI 54 to 243) additional contacts per 1000 patients. This increase persisted for 5 years. Out-of-hours GP contacts increased the first year, RR 1.04 (95% CI 0.99 to 1.09), corresponding to 16 (95% CI −5 to 37) contacts per 1000 patients. Planned hospital contacts increased 3% (95% CI 2 to 4) in year 1, persisting into year 5. Acute hospital contacts increased 5% (95% CI 3 to 7), primarily in the first year. These 1-year effects corresponded to 51 (95% CI 18 to 83) planned and 13 (95% CI 7 to 18) acute hospital contacts per 1000 patients. Mortality was unchanged up to 5 years after discontinuity.

Conclusion Regular GPs retirement and relocation were associated with small to moderate increases in healthcare use among listed patients, while mortality was unaffected.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Having a stable, ongoing relationship with a general practitioner (GP) is associated with positive health outcomes for patients and lower healthcare costs.

WHAT THIS STUDY ADDS

⇒ With more than a decade of personal linked complete data, we found that people assigned to a Regular GP that permanently retired or moved, had small to moderate increases in healthcare use, and no change in mortality.

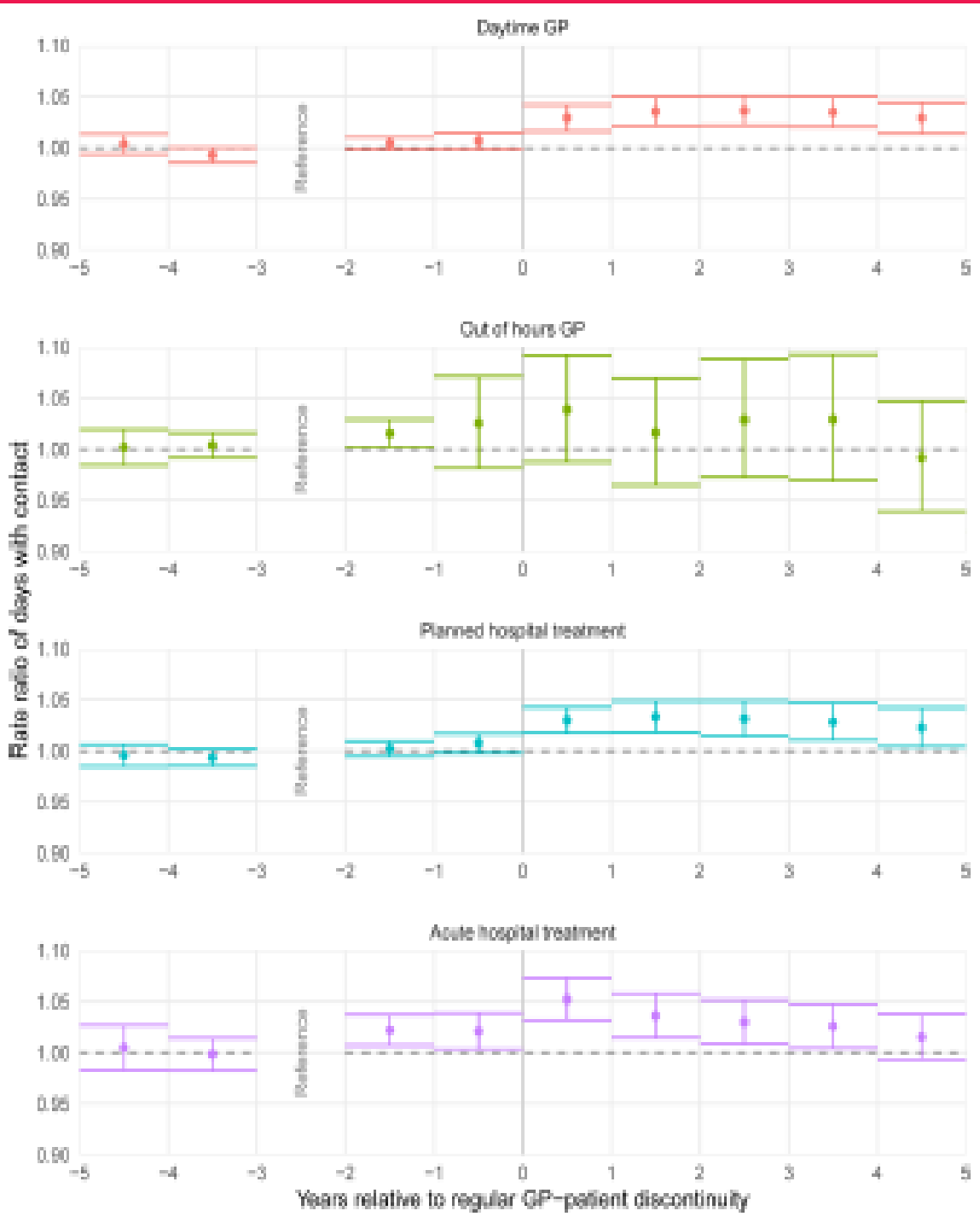
HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The findings suggest robustness in the Norwegian healthcare system to individuals losing their Regular GP d to retirement or relocation.

⇒ Further studies are required to detect any high-risk patient groups and cau specific mortality to accommodate potentially targeted prevention.

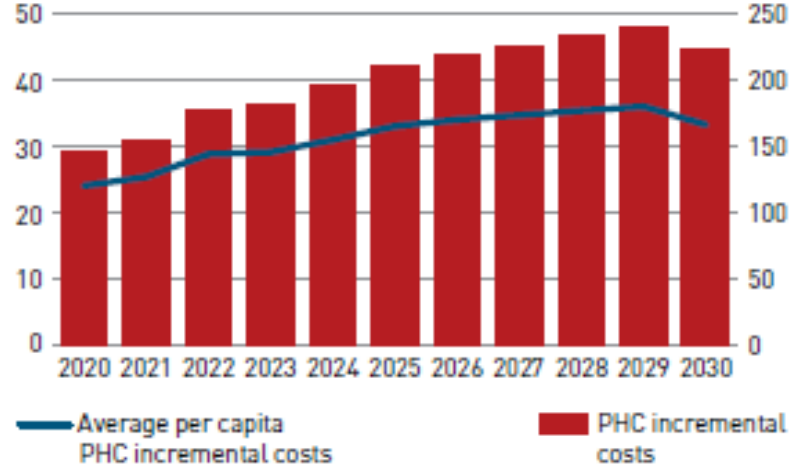
INTRODUCTION

Continuity in the doctor-patient relation is a core value in primary care, and studies suggest that being cared for by the same GP over time is associated with pa satisfaction, improved patient outc and reduced healthcare costs.[1 2] How this topic spans various dimension care,[3] which complicates our abili discern how specific changes in conti affect outcomes. In Norway, the Re GP scheme facilitates interpersonal c nuity between a named GP and a spec



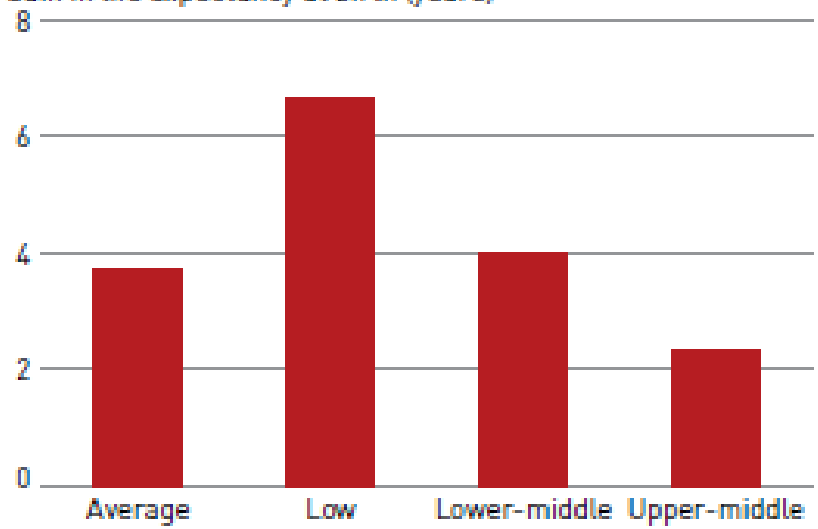
El informe representa una clara llamada para la acción a los gobiernos de todos los países para invertir un 1% adicional del Producto Interior Bruto (PIB) en Atención Primaria de Salud, que puede ser alcanzado bien mediante inversiones adicionales, o bien a través en ganancias en eficiencia o equidad

FIGURE 4.11 About US$200 billion a year of additional investment in primary health care is needed to reach universal health coverage by 2030



Source: Stenberg et al. 2019 Lancet Global Health *[19]*

FIGURE 4.13 Average life expectancy gain from further primary health care investment



Source: Stenberg et al. *[19]*

¿Cuánto y en qué se invierte en AP tras la pandemia?

Fecha	Monto	Plan	Destino
Abril 2023	493,8 millones	Plan de Mejora de Infraestructuras de Atención Primaria (MINAP)	• Mejora de las infraestructuras de los centros • Ampliación y renovación de su equipamiento clínico
	85,3 millones	Marco Estratégico de Atención Primaria y Comunitaria	• transformación digital de la Atención Primaria y Comunitaria (APyC)
Julio 2024	172 millones	Comisión de Atención Primaria y Comunitaria (CAPYCO)	• Formación de los profesionales • Mejora de la coordinación. • Adquisición de nuevo equipamiento médico

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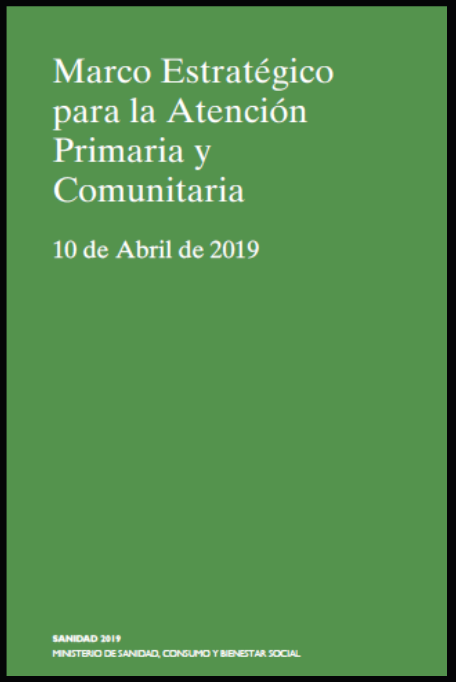
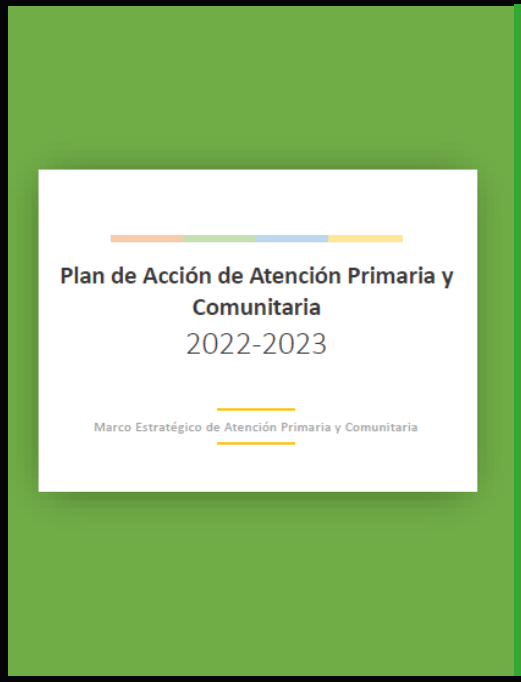
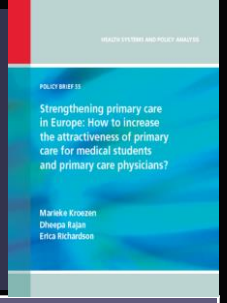
¿Qué cambios son necesarios?

Alternativas





6 líneas de intervención



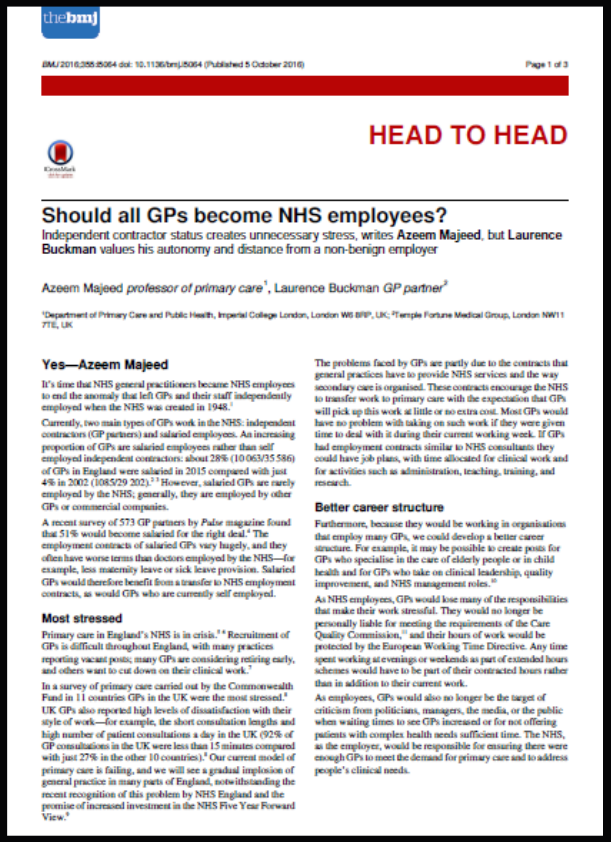
Ámbito	Responsabilidad	Barreras
Educación médica	Ministerio de Universidades	Universidades
Planificación del Recurso Humano	Ministerio de Sanidad	Partidos políticos
Financiación	Ministerio de Hacienda	Hacienda Hospitales Lobby médicos
Ambiente, condiciones de trabajo Equilibrio vital	Gobierno/CCAA	Sindicatos Ministerio de Hacienda
Modelo de Atención Primaria	Ministerio de Sanidad CCAA	Múltiples
Zonas desatendidas (rurales, remotas, violentas)	Gobierno /CCAA	Múltiples

¿Sirve aún una Atención Primaria de 1982?

Comparación internacional: Medicina Familiar en Grado

Universidad	Imperial College	Queen Mary	Edimburgh	Maastricht	Duke (USA)	Brown	Toronto	Fiocruz	Universidad de Chile
Profesores	MG	MG	MG	MF	MF	MF	MF	Salubristas, MF	MF,MG, Otros
Atención a pacientes	Si	Si	Si	Si	Si		Si	Si	Si (6º y 7º)
Continuidad	Si Longitudinal Integrated Apprendiceship	Si	Si Longitudinal Integrated Clerkship)	Si	Si (PCLT)	Si (track)	Si (Track)	Si	No
Departamento MF/MG	Si	Si	Si	Si	Si	Si	Si	Si	Si

¿Hasta cuando la plaza en propiedad?



thebmj

BMJ 2016;355:i5064 doi: 10.1136/bmj.i5064 (Published 5 October 2016) Page 1 of 3

HEAD TO HEAD

Should all GPs become NHS employees?

Independent contractor status creates unnecessary stress, writes **Azeem Majeed**, but **Laurence Buckman** values his autonomy and distance from a non-benign employer

Azeem Majeed *professor of primary care*[1], Laurence Buckman *GP partner*[2]

[1]Department of Primary Care and Public Health, Imperial College London, London W6 8RP, UK; [2]Temple Fortune Medical Group, London NW11 7TE, UK

Yes—Azeem Majeed

It's time that NHS general practitioners became NHS employees to end the anomaly that left GPs and their staff independently employed when the NHS was created in 1948.[1]

Currently, two main types of GPs work in the NHS: independent contractors (GP partners) and salaried employees. An increasing proportion of GPs are salaried employees rather than self employed independent contractors: about 28% (10 063/35 586) of GPs in England were salaried in 2015 compared with just 4% in 2002 (108/5029 202).[2 3] However, salaried GPs are rarely employed by the NHS; generally, they are employed by other GPs or commercial companies.

A recent survey of 573 GP partners by *Pulse* magazine found that 51% would become salaried for the right deal.[4] The employment contracts of salaried GPs vary hugely, and they often have worse terms than doctors employed by the NHS—for example, less maternity leave or sick leave provision. Salaried GPs would therefore benefit from a transfer to NHS employment contracts, as would GPs who are currently self employed.

Most stressed

Primary care in England's NHS is in crisis.[5 6] Recruitment of GPs is difficult throughout England, with many practices reporting vacant posts; many GPs are considering retiring early, and others want to cut down on their clinical work.[7]

In a survey of primary care carried out by the Commonwealth Fund in 11 countries GPs in the UK were the most stressed.[8] UK GPs also reported high levels of dissatisfaction with their style of work—for example, the short consultation lengths and high number of patient consultations a day in the UK (92% of GP consultations in the UK were less than 15 minutes compared with just 27% in the other 10 countries).[8] Our current model of primary care is failing, and we will see a gradual implosion of general practice in many parts of England, notwithstanding the recent recognition of this problem by NHS England and the promise of increased investment in the NHS Five Year Forward View.[9]

The problems faced by GPs are partly due to the contracts that general practices have to provide NHS services and the way secondary care is organised. These contracts encourage the NHS to transfer work to primary care with the expectation that GPs will pick up this work at little or no extra cost. Most GPs would have no problem with taking on such work if they were given time to deal with it during their current working week. If GPs had employment contracts similar to NHS consultants they could have job plans, with time allocated for clinical work and for activities such as administration, teaching, training, and research.

Better career structure

Furthermore, because they would be working in organisations that employ many GPs, we could develop a better career structure. For example, it may be possible to create posts for GPs who specialise in the care of elderly people or in child health and for GPs who take on clinical leadership, quality improvement, and NHS management roles.[10]

As NHS employees, GPs would lose many of the responsibilities that make their work stressful. They would no longer be personally liable for meeting the requirements of the Care Quality Commission,[11] and their hours of work would be protected by the European Working Time Directive. Any time spent working at evenings or weekends as part of extended hours schemes would have to be part of their contracted hours rather than in addition to their current work.

As employees, GPs would also no longer be the target of criticism from politicians, managers, the media, or the public when waiting times to see GPs increased or for not offering patients with complex health needs sufficient time. The NHS, as the employer, would be responsible for ensuring there were enough GPs to meet the demand for primary care and to address people's clinical needs.

- Convocatoria
  - Periodicidad
  - Intencionalidad
- Prueba
- Latencia
- Continuidad
- Acreditación

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Reviving clinical governance? A qualitative study of the impact of professional regulatory reform on clinical governance in healthcare organisations in England

Tristan Price[a,*], John Tredinnick-Rowe[b], Kieran Walshe[c], Abigail Tazzyman[d], Jane Ferguson[e], Alan Boyd[e], Julian Archer[a], Marie Bryce[a]

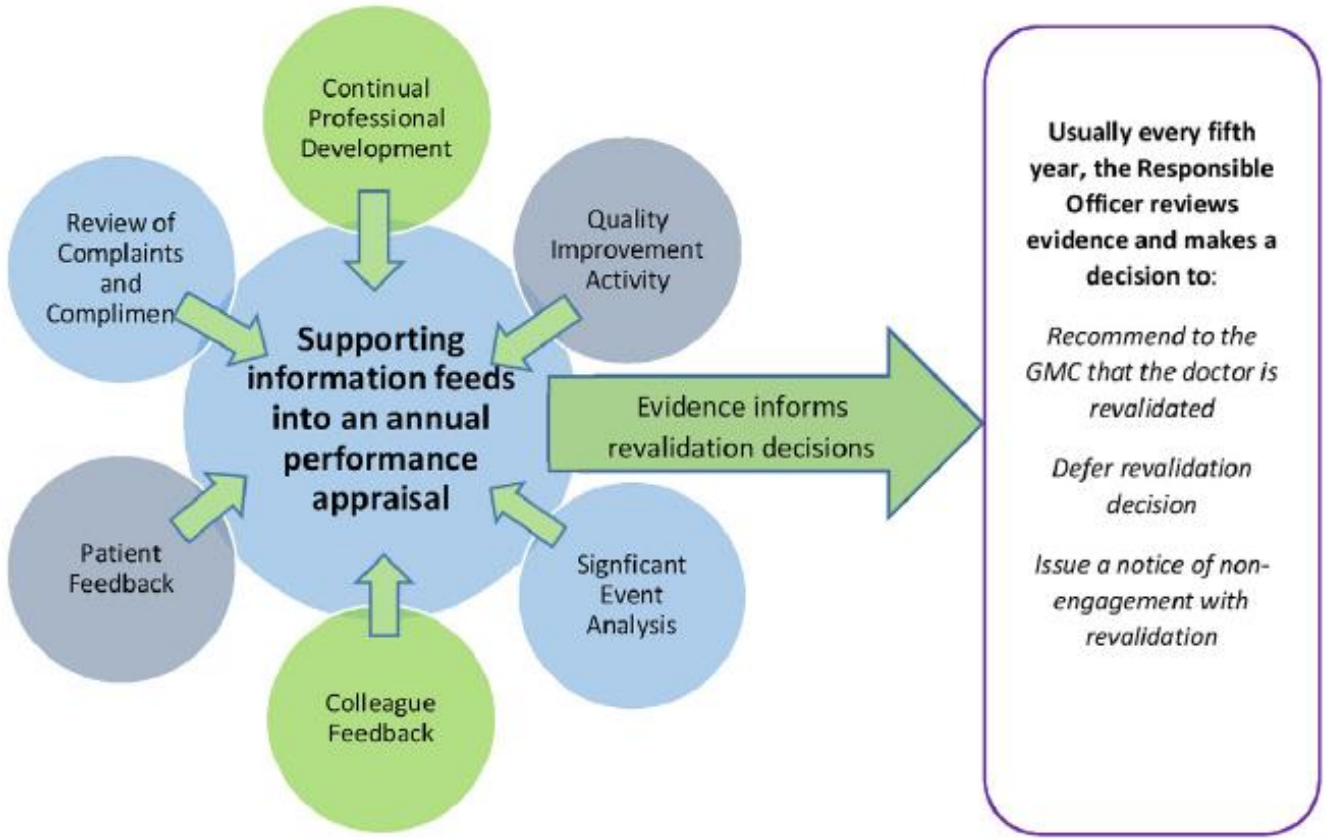
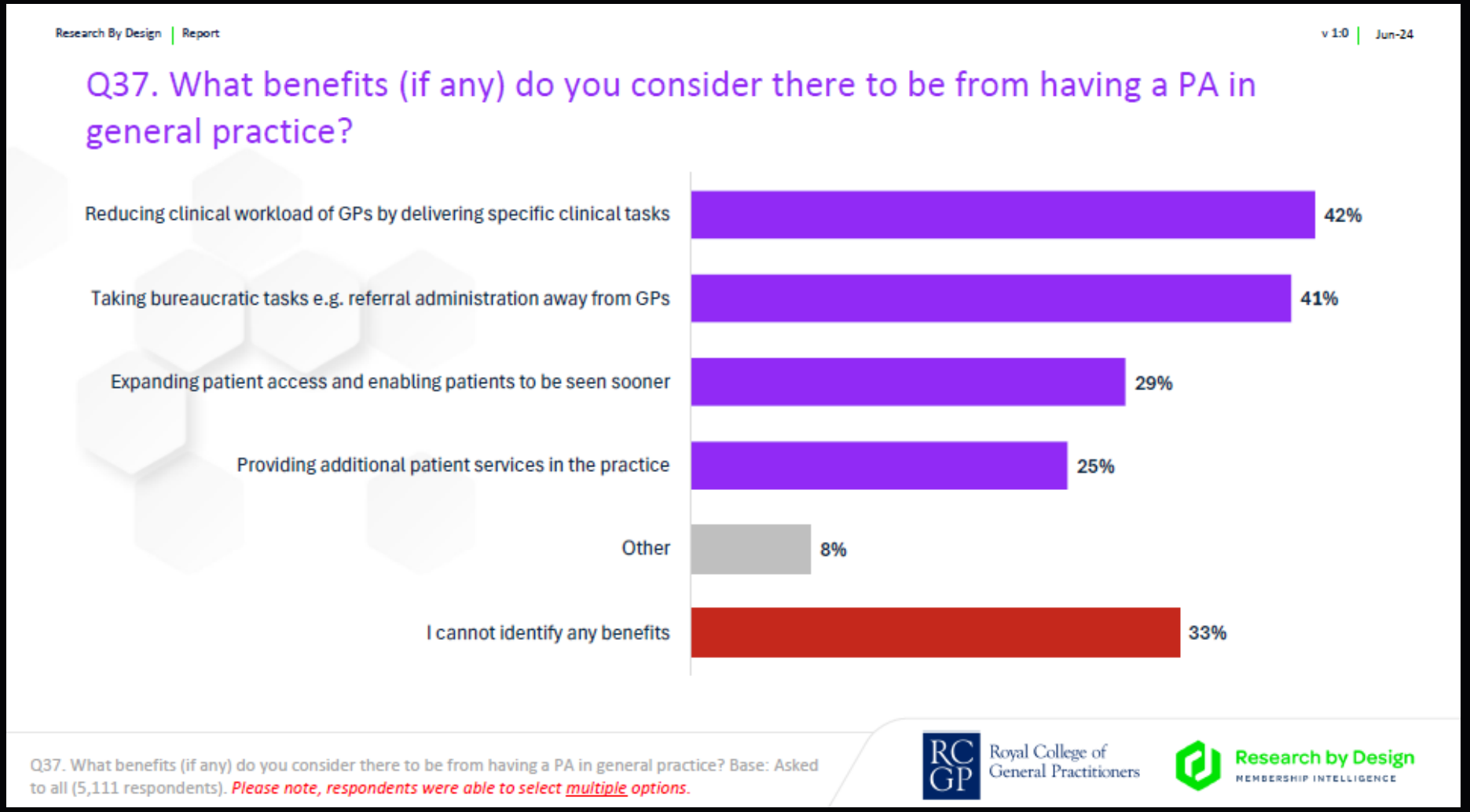


Fig. 2. Supporting information, appraisal and revalidation decisions.

Equipos multiprofesionales: el fin del "Llanero Solitario"

CÍRCULOS	PERFILES
Núcleo	Médico de familia/Médico general Enfermera/Agente comunitario TENS
	Asistente Médico (Medical Assistant) Prestadores de Práctica Avanzada (Advanced Practice Providers): -Nurse Practitioner -Ph-ysician Assistant Agente comunitario/Promotor/ - Trabajo social
2º Círculo (Equipo extendido)	Odontología Matrona Fisioterapia Psicólogo Nutricionista Farmacéuticos
3º Círculo (Equipo extendido)	Profesionales de la Salud pública Gestor de población (Panel manager) Gestor de navegación (Care navigator) Promotores de activos (Health coaches) ¿Explotador de datos/diseñador de Prompts
4º Círculo (Coproducción)	Sanadores de la Medicina tradicional Cuidadores Pacientes

El conflicto del 2024 en el NHS: Physician Associates



Atención Primaria.
Vol. 27. Núm. 5. 31 de marzo 2001

EDITORIAL

Diez minutos, ¡qué menos!

"ya tenemos cierta edad como para andar esperando que mamá-papá-empresa venga a poner orden en nuestra habitación".

" Es cierto que no es tarea fácil, pero no por ello debemos adoptar una actitud pasiva esperando que «fuerzas superiores» vengan a resolver nuestros problemas, definiendo adecuadamente las funciones o con monsergas normativas similares".

- Se abre la bolsa
- Se anuncia próxima concurso de traslado
- Las sociedades de Primaria ven prematuro el acuerdo.
- La desmotivación de los profesionales es creciente
- Ministro resalta los avances de la reforma de la AP de 1984.

¿Está en crisis el actual modelo sanitario del Sistema Público de Salud?

¿Nuestro modelo sanitario se basa en la atención primaria?

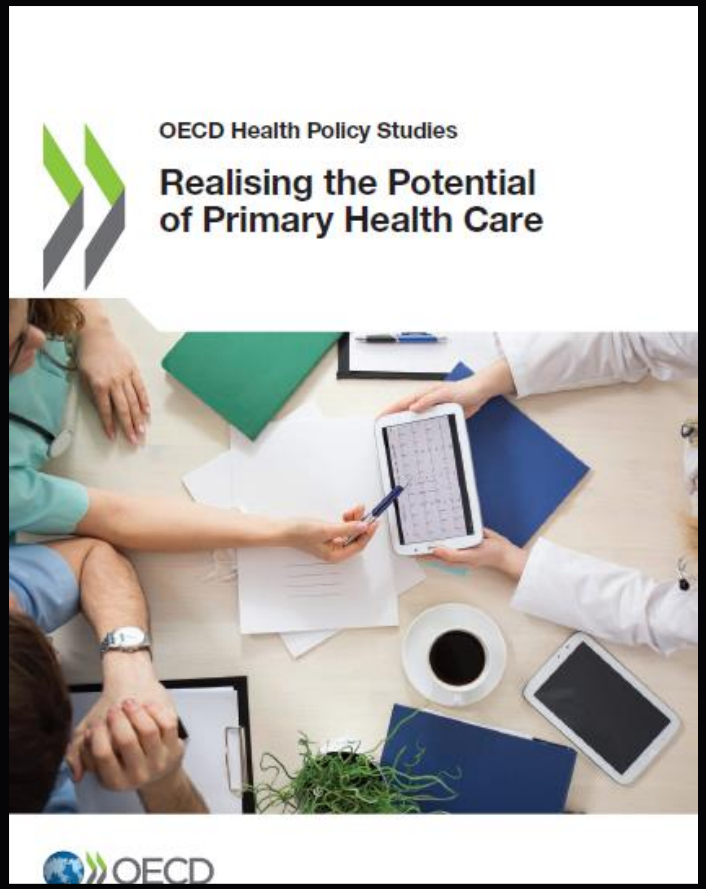
La crisis de la AP: cómo este nivel de atención acaba colapsando

¿Qué cambios son necesarios?

¿ALTERNATIVAS?

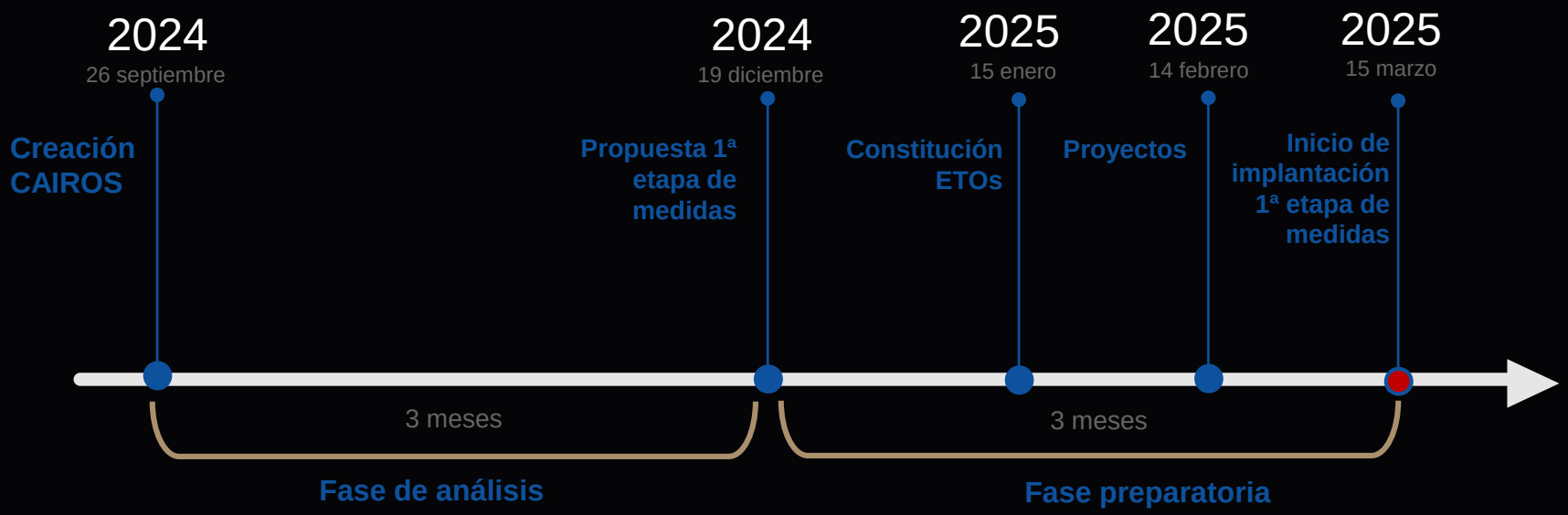
“Seguir como hasta ahora no es una opción”

(business as usual in health care is no longer an option)



Comité de Evaluación, Innovación y Reforma Operativa del Sistema de Salud (CAIROS)

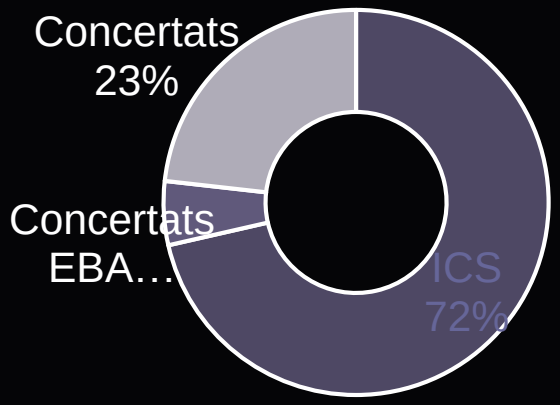
Cronograma 2024-2025



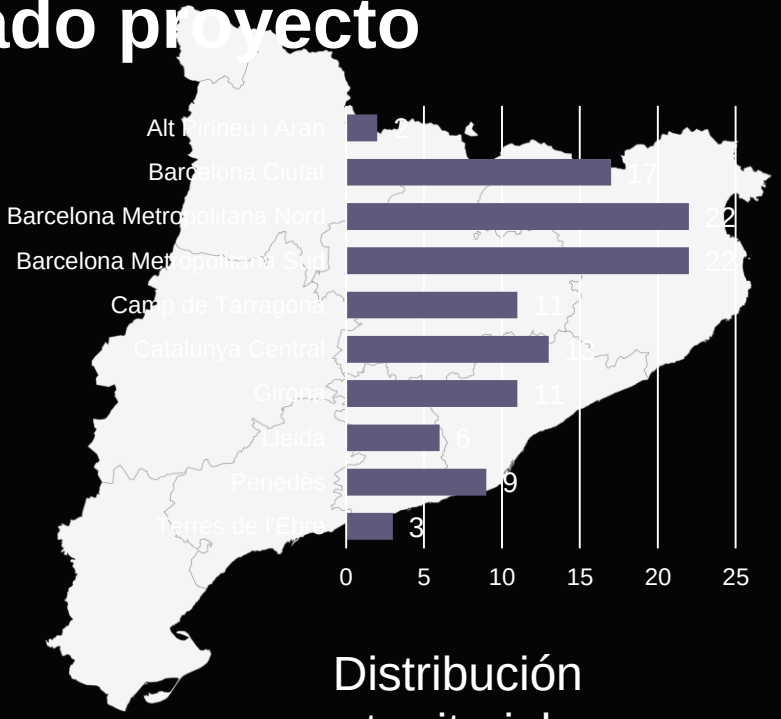
- **Escuchar** (CAIROS Abierto)
- **Leer** (Informes)
- **Explorar** (Experiencias internacionales)

J.Casajuana, 2025

158 interesados (40%)
116 han presentado proyecto



Distribución
proveedor

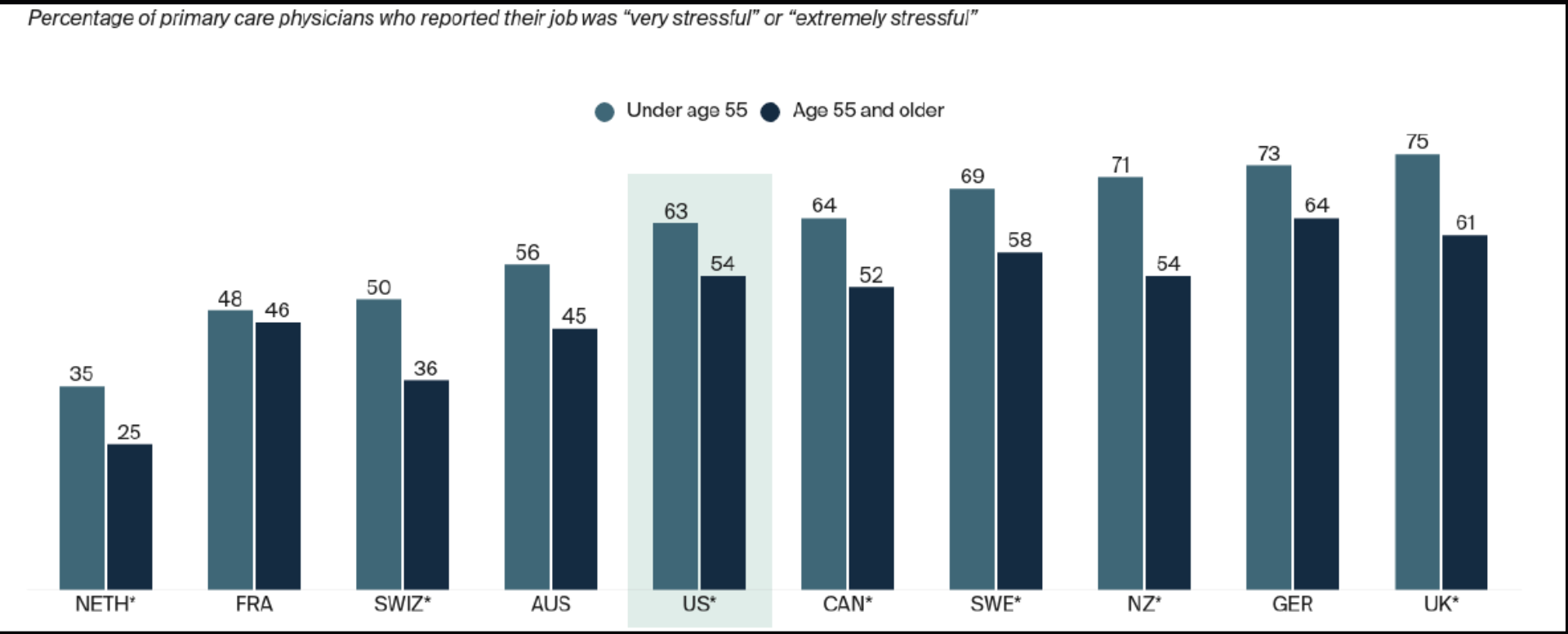


Distribución
territorial

J.Casajuana, 2025

Quemados

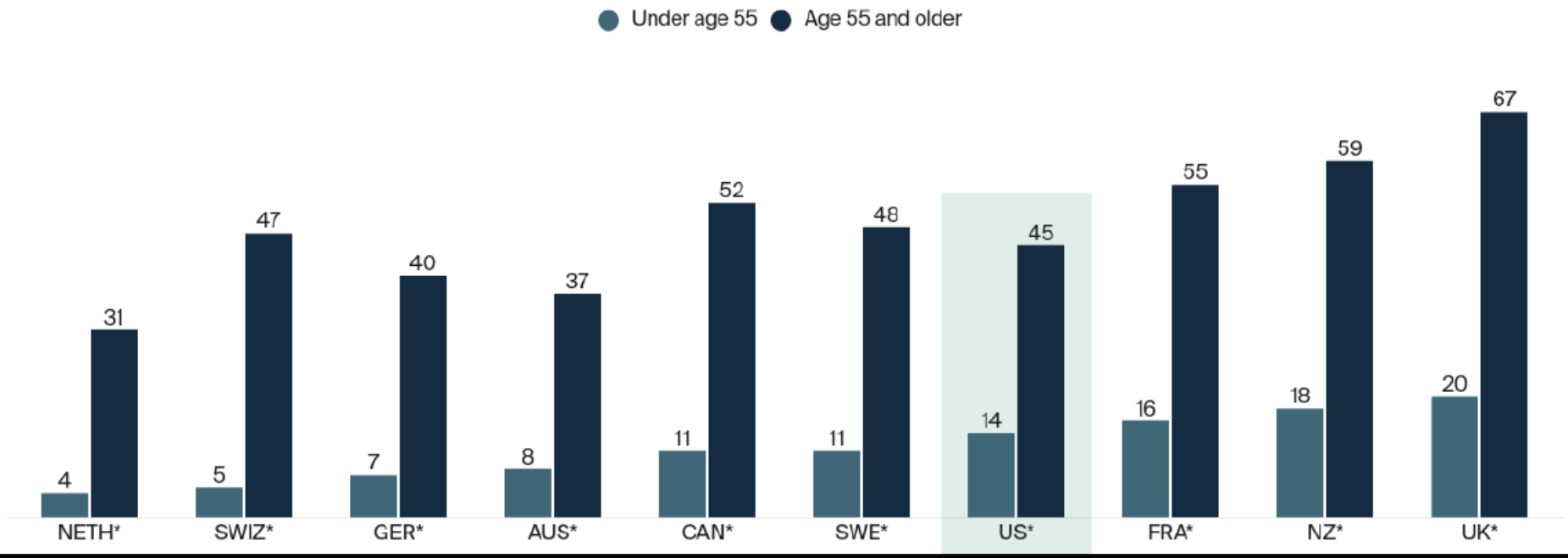
The Commonwealth Fund



Y pensando en abandonar

The Commonwealth Fund

*Percentage of primary care physicians who said they plan to stop seeing patients in the next one to three years^*



El burnout en España

(Gac Sanit 2024;38:102384)

Prevalencia del síndrome de *burnout* en médicos que trabajan en España: revisión sistemática y metaanálisis

Antonio Pujol-de Castro[a,*], Grecia Valerio-Rao[b], Pablo Vaquero-Cepeda[c] y Ferrán Catalá-López[d,e,f]

[a] *Servicio de Medicina Preventiva, Hospital Clínico San Carlos, Madrid, España*
[b] *Servicio de Medicina Preventiva, Hospital Universitario Central de Asturias, Oviedo, España*
[c] *Servicio de Medicina Preventiva, Complejo Asistencial Universitario de Salamanca, Salamanca, España*
[d] *Departamento de Planificación y Economía de la Salud, Escuela Nacional de Sanidad, Instituto de Salud Carlos III, Madrid, España*
[e] *Centro de Investigación Biomédica en Red de Salud Mental (CIBERSAM), Instituto de Salud Carlos III, Madrid, España*
[f] *Clinical Epidemiology Program, Ottawa Hospital Research Institute, Ottawa, Ontario, Canada*

En esta revisión sistemática y metaanálisis de 67 estudios (16.076 participantes) se observó una prevalencia de *burnout* del 24%. Se encontraron diferencias según el criterio diagnóstico. La prevalencia de *burnout* fue del 18% cuando se utilizó un criterio diagnóstico más conservador (incluyendo las tres dimensiones afectadas), y las cifras fueron más altas cuando se aplicaron criterios menos estrictos (del 29% para dos dimensiones y del 51% para una dimensión).

#legermaleve

Tidsskriftet

ARTIKLER FAGOMRÅDER UTGAVER PODKAST PUBLISERING LEGEJOBBER SØK

A compassionate health service

ARTICLE
REFERENCES
COMMENTS (1)

Kari Tveito About the author

#legermåleve may go down in history as the action campaign that changed Norway's health sector.

Photo: Einar Nilsen

On 4 June 2023, a young female hospital doctor took her own life. A few days later, her partner wrote a Facebook post urging doctors and healthcare workers to take action to address their working conditions. He told how his loved one had been overworked and had developed a mental illness that was partly linked to major pressure at work.

Five months later, the Facebook group '#legermåleve' (doctors must live) has over 5,000 members. Doctors all over Norway have appeared in newspapers, on TV and on the radio, sharing stores of indefensible working conditions, burnout, long

NORWEGIAN

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doi: 10.4045/tidsskr.23.0724
PlumX Metrics

PDF
PRINT

Medicine, Health Care and Philosophy
https://doi.org/10.1007/s11019-025-10258-7

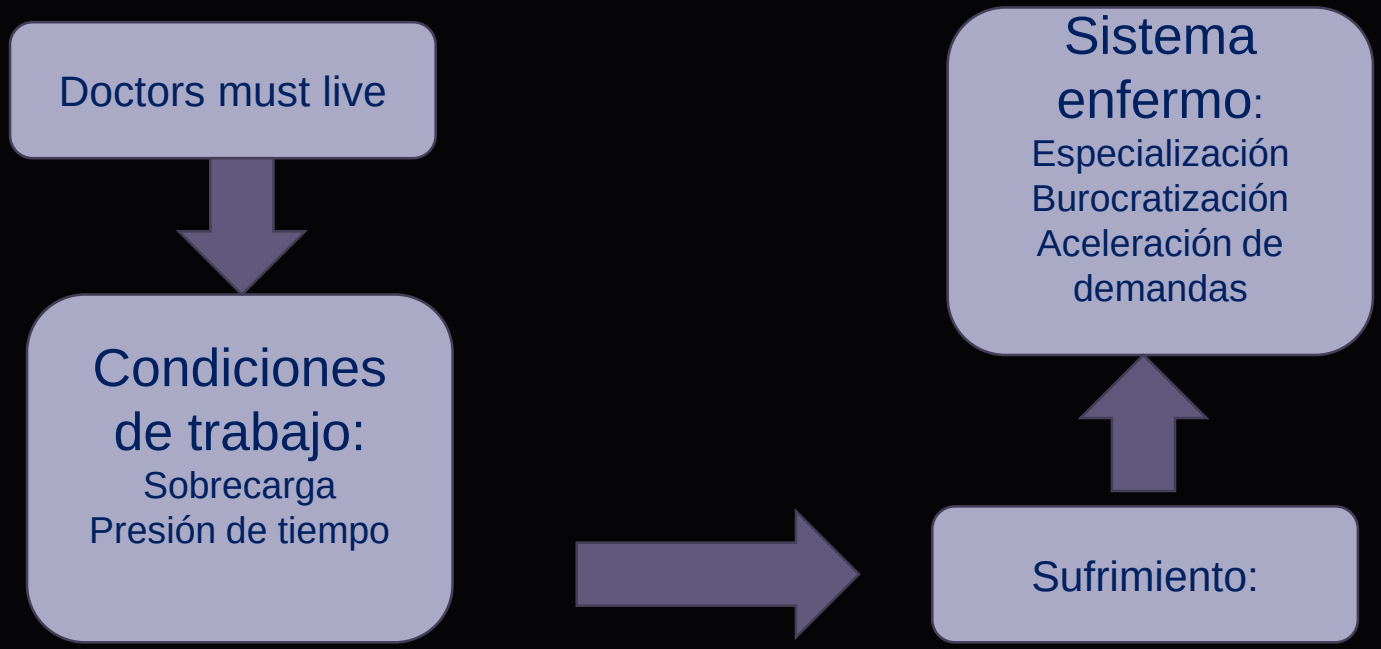
SCIENTIFIC CONTRIBUTION

«Doctors must live»: a care ethics inquiry into physicians' late modern suffering

Caroline Engen[1,2,3]

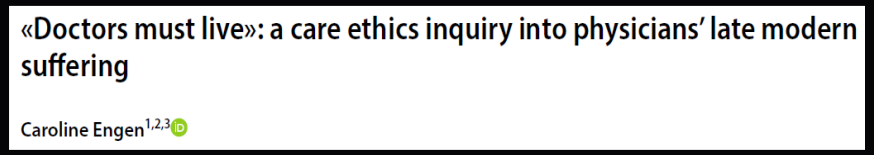
Accepted: 22 January 2025

Metodología basada en heurísticos (Vosman, Niemeijer)



1. Thinking along
(Pensar en conjunto)

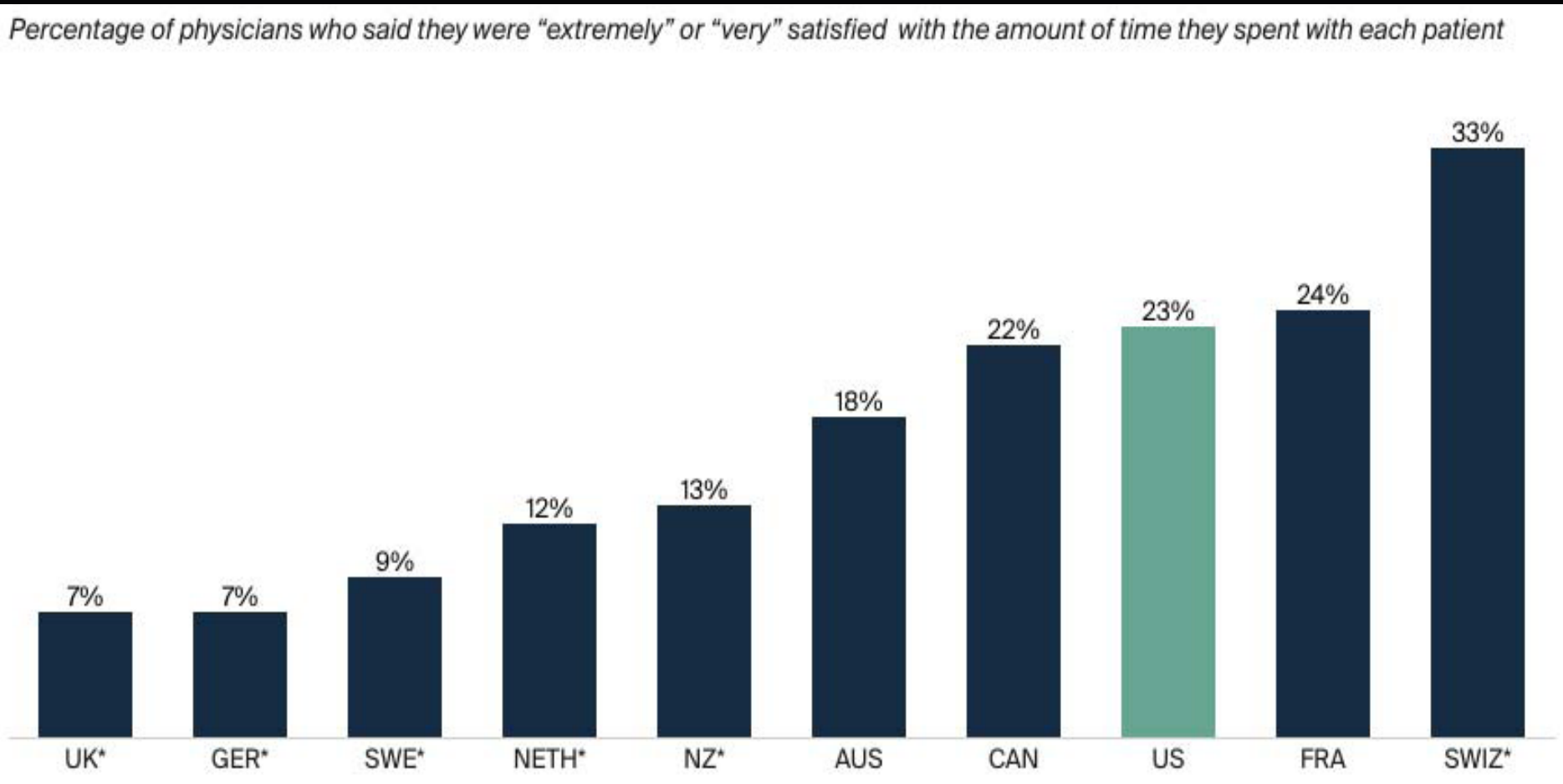
- Sobrecarga
  - Exceso de pacientes
  - Exceso de tareas burocráticas
- (In) Competencia
- (In) Suficiencia/culpa
- Responsabilidad
- Sufrimiento


«Doctors must live»: a care ethics inquiry into physicians' late modern suffering

Caroline Engen[1,2,3]

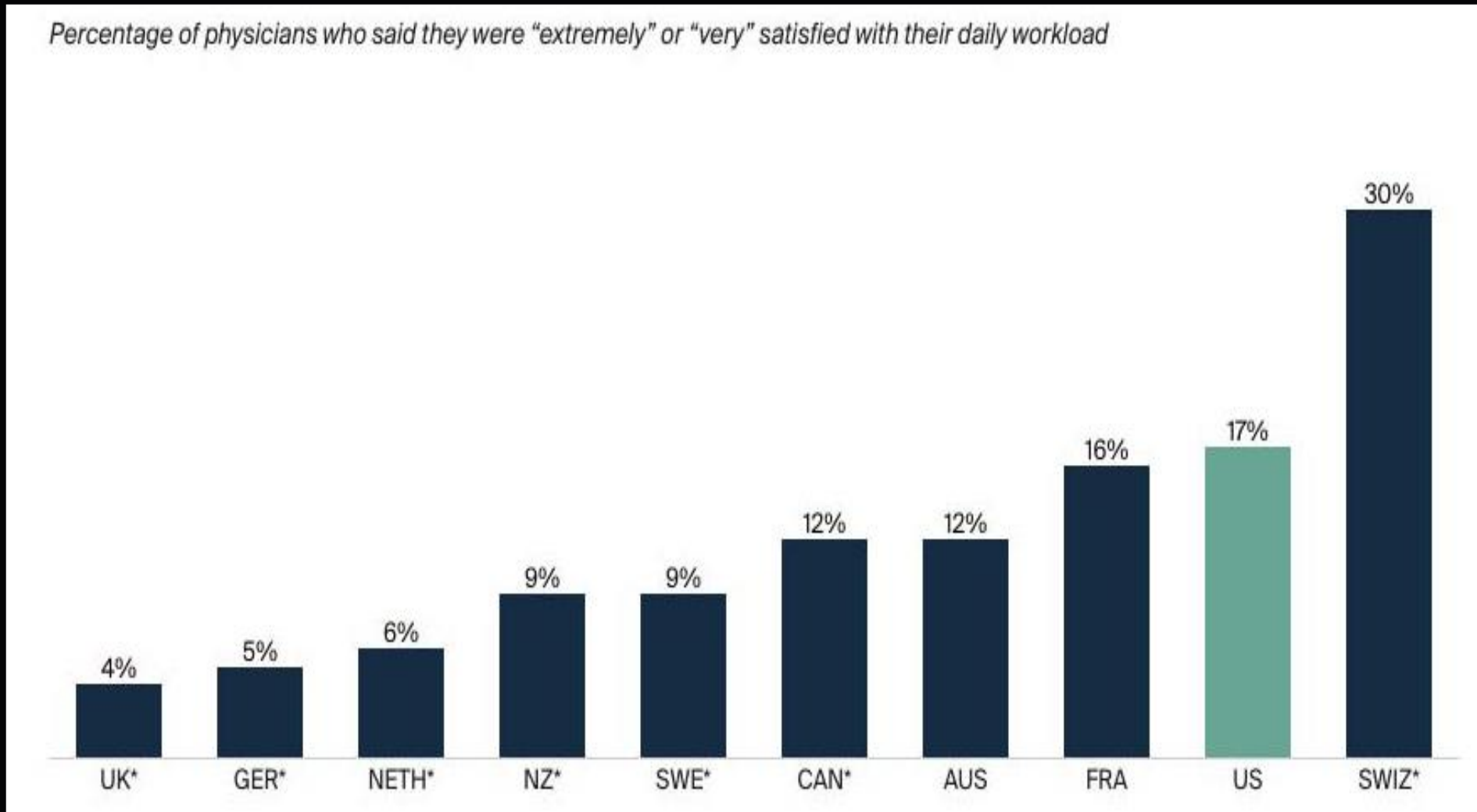
Hartos de la falta de tiempo

The Commonwealth Fund



Hartos de Sobrecarga

The Commonwealth Fund

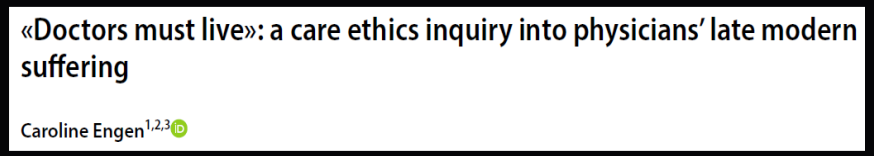


Pequeñas renuncias sin importancia

- A no tener suplente ante curso, enfermedad, vacaciones
- A no tomar la baja para no perjudicar a mis compañeros
- A no gestionar mi propia agenda
- A aceptar que cada paciente tiene 5 minutos
- A aceptar la demora cero
- A Historias clínicas centradas en la organización
- A la confidencialidad de los datos de mis pacientes
- A aceptar compromisos de actividad
- A realizar tareas que antes hacían otros (anticoncepción, ecografías, INR,…) sin recursos ni tiempo adicional.
- A hacer nuevas tareas (teleconsultas, correo, Whatsapp,..)
- A aceptar modelos sin evidencia (estratificación de pacientes, organizaciones integradas, cribados sin demostración de reducción de mortalidad,acreditaciones,…)

Counter-thinking
(Réplica)

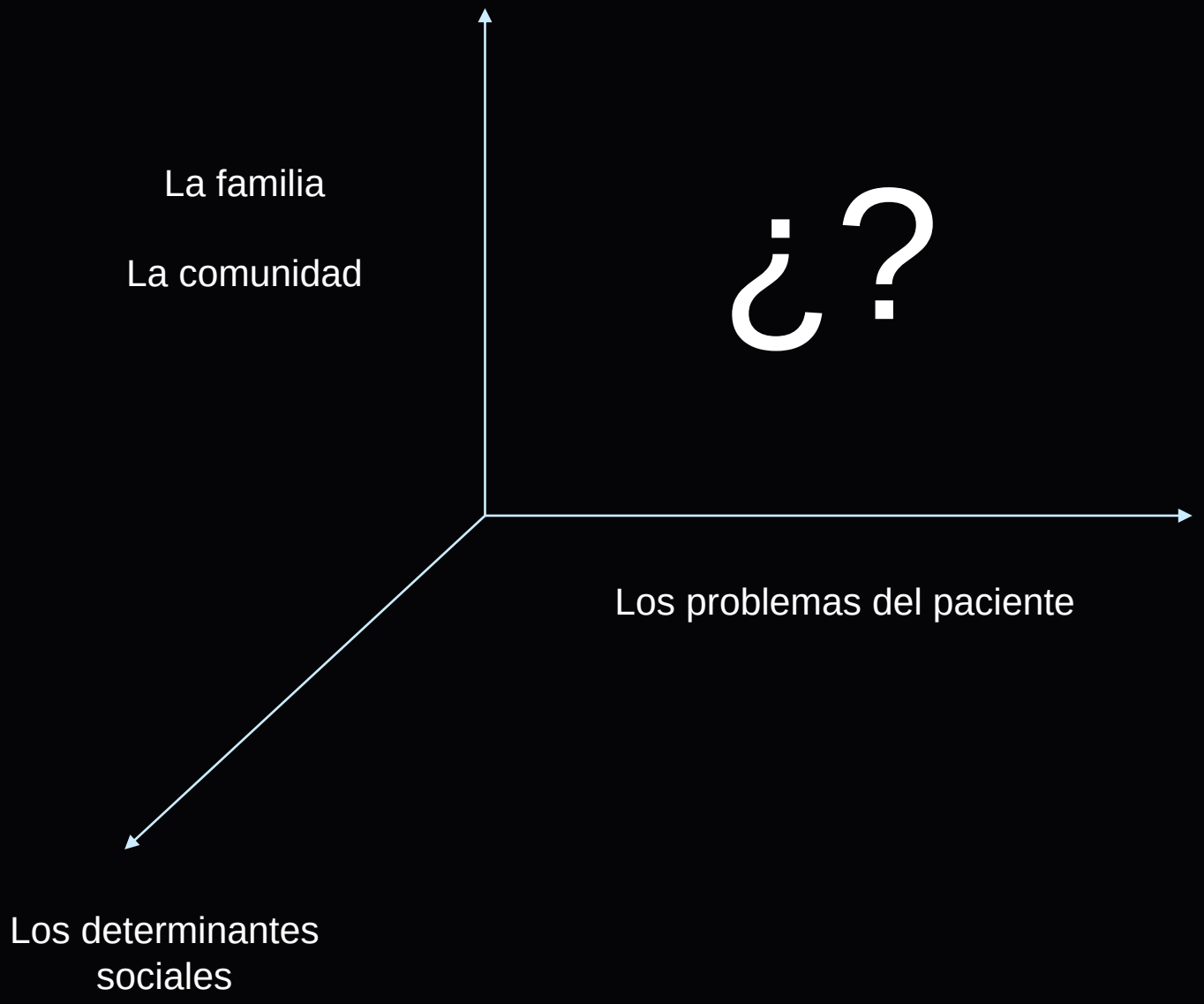
- Replantear el marco (Framing)
  - Cantidad de trabajo
    - ¿en comparación con quien?
  - Calidad del trabajo
    - rediseño continuo
    - Renegociación continua del rol:
    - “la medicina moderna se caracteriza por un enfoque más colectivo y regulado, en detrimento de los roles tradicionales y la autonomía de la profesión médica
    - “ La reorganización neoliberal de las organizaciones de atención resultó en que las enfermeras ya no podían realizar su trabajo de la forma en que se les había enseñado ni según los estándares que consideraban apropiados y responsables considerándolo como una violación de su integridad profesional “(Thomassen et al., 2017).



“Los lineamientos de la atención médica parecen cada vez más productos de protocolos empíricos cuya naturaleza hace que se considere a los pacientes unidades estandarizadas de enfermedad. Estos protocolos no dan cabida al relato de cada individuo, a los valores, aspiraciones y prioridades de cada persona diferente y a la forma en que éstas cambian con el tiempo”

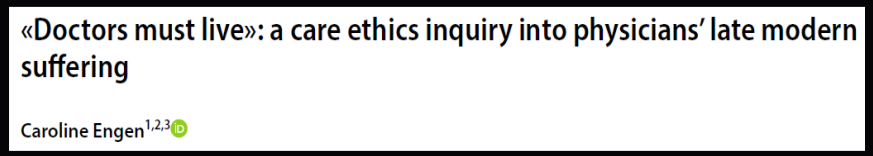
(Iona Heath)

La inalcanzable aspiración de la APS



Individuo-población

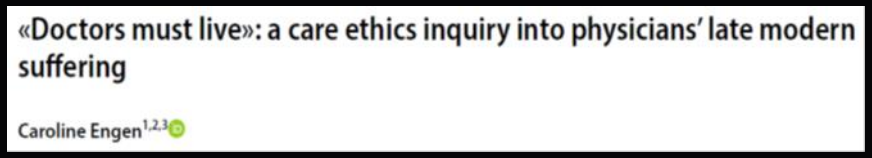
- Se ha producido la expansión del alcance de la medicina, integrando la salud no solo como una preocupación de la díada profesional-paciente, sino como un objetivo político y social dirigido a poblaciones. Esta integración ha difuminado los límites entre la atención clínica y la salud pública, transformando no solo lo que se considera "bueno" en la práctica médica, sino también alterando fundamentalmente cómo los médicos se perciben a sí mismos como actores morales.
- Los médicos noruegos parecen adoptar implícitamente una postura utilitarista donde el objetivo principal, si no la razón de ser en sí misma, del sistema de atención médica es maximizar la salud en la población mediante alguna métrica, ya sean AVAC u otras.
- Una característica típica del estado biopolítico, donde los médicos adoptan e implementan las prioridades del estado, centrándose en controlar y mejorar la salud de las poblaciones en lugar de priorizar la atención individual (Suijker 2023).


«Doctors must live»: a care ethics inquiry into physicians' late modern suffering

Caroline Engen[1,2,3]

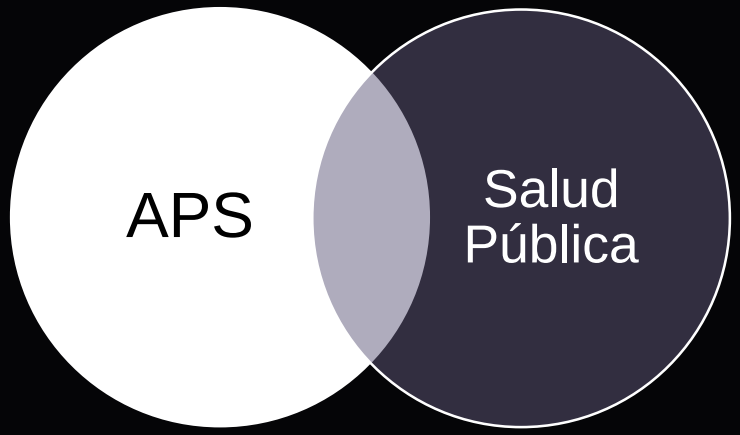
El sufrimiento de los profesionales como tensión

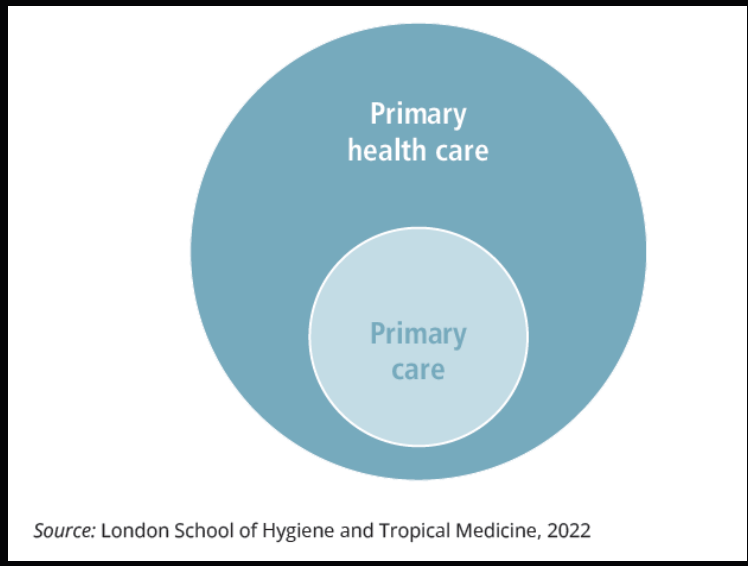
- Entre tres nociones rivales de ética:
  - el imperativo utilitario de maximizar la salud de la población.
  - El ideal de autonomía y elección individual.
  - La experiencia tácita y relacional del cuidado.



¿Atención Primaria

¿o Salud Pública?

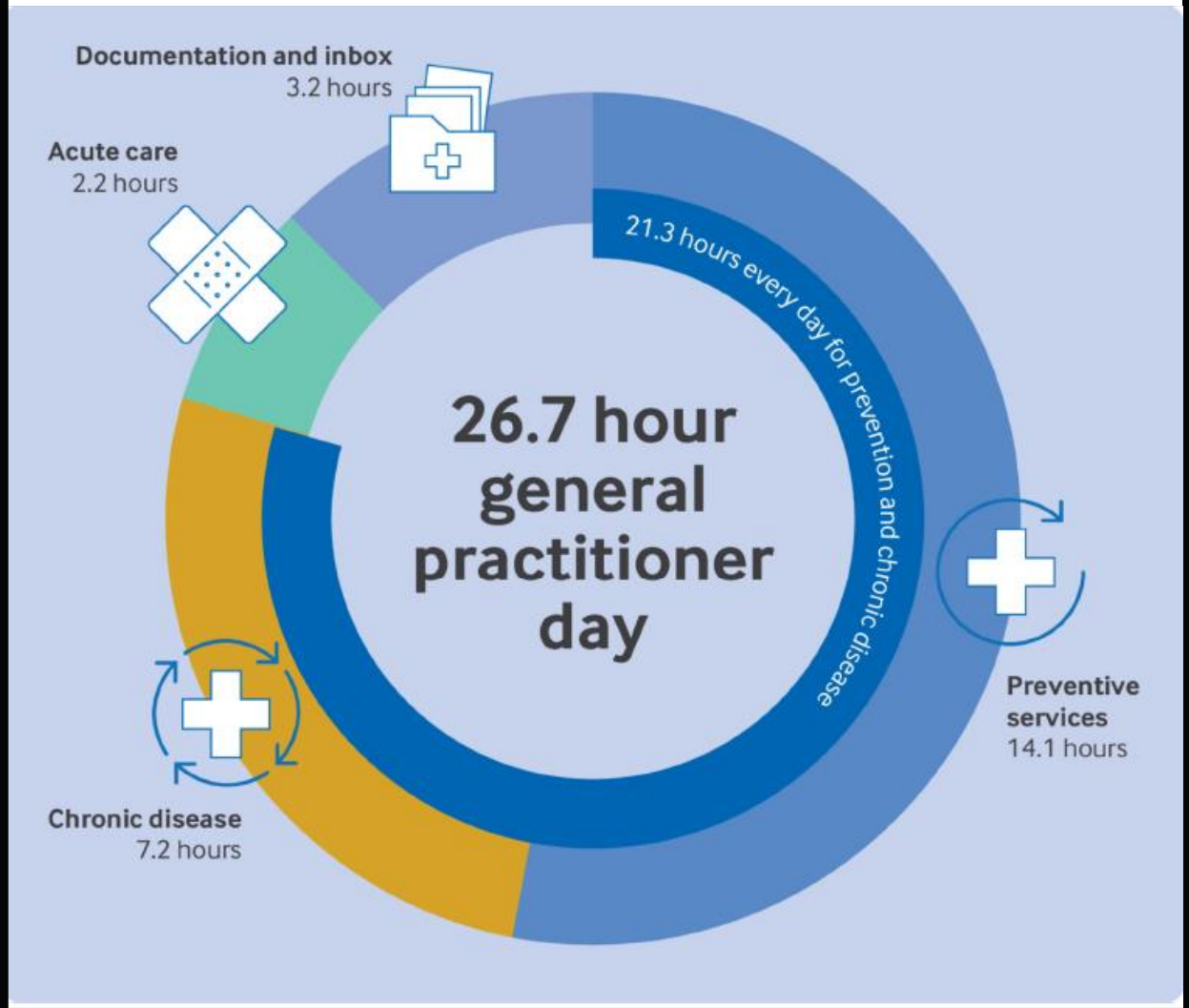




Sacrificing patient care for prevention: distortion of the role of general practice

Expansion of preventive clinical recommendations in primary care has had the unintended consequence of destabilising this foundation of the healthcare system, argue Minna Johansson and colleagues

Stephen A Martin, [1] Minna Johansson, [2,3] Iona Heath, [4] Richard Lehman, [5] Christina Korownyk[6]



the bmj | BMJ 2025;388:e080811 | doi: 10.1136/bmj-2024-080811

A. Prioritise prevention

To prioritise prevention, acute and chronic disease care would be eliminated. Promoters of prevention would select which recommended prevention interventions could compose entirety of 10 hour day

Intended outcome

No one becomes sick (disease is prevented)

Actual outcome

Patient satisfaction (poor)
Should anyone continue to become sick, they cannot be seen in primary care

GP satisfaction (poor)
GPs are unable to care for the sick, leading to ethical stress and existential questions about their intensive, lengthy training and purpose
Relatively few patients benefit from primary prevention

Societal cost (high)
Management of sick patients (acute and chronic) will be transitioned to emergency departments, urgent care, or other settings - or patients forgo care entirely

B. Reduce panel size

In order to complete the current recommendations for prevention, chronic, and acute care within a 10 hour day, GPs would reduce their patient panels by approximately two thirds

Intended outcome

Each patient receives all recommendations for prevention, chronic, and acute care

Actual outcome

Patient satisfaction (poor)
Two thirds of patients would not have a GP

GP satisfaction (mixed)
May improve GPs sense of accomplishment and work sustainability
Would no longer care for two thirds of their patients

Societal cost (high)
Two thirds of established patients would no longer have a GP (in addition to people already without a GP)
Management of sick patients would be similar to (A)

C. Less time with patients

In order to complete current recommendations for prevention, chronic, and acute care within a 10 hour day, GPs would spend less time with patients by speaking faster, interrupting patients sooner, or communicating through form letters, AI, and group visits

Intended outcome

Each patient receives all recommendations for prevention, chronic, and acute care

Actual outcome

Patient satisfaction (poor)
Attention to additional patient concerns (eg, chest pain, depressed mood) would not be possible

GP satisfaction (poor)
Exhaustion and ethical stress leading to GP burnout

Societal cost (high)
Longer term GP supply is threatened by poor work environment and job satisfaction
Increased errors due to rushed communication

D. Primary care teams

In order to complete the current recommendations for prevention, chronic, and acute care within a 10 hour day, primary care teams would be employed to assist

Intended outcome

Each patient receives all recommendations for prevention, chronic, and acute care

Actual outcome

Patient satisfaction (moderate)
Implementing all preventive recommendations that apply to each individual will require a massive workforce - while the likelihood of individual patient benefit will remain small
Relational continuity between patient and healthcare personnel diminishes, which in turn may worsen health outcomes

GP satisfaction (mixed)
May reduce GPs' sense of being overwhelmed
GPs become consultants with limited personal knowledge or relational continuity with patients
May lead to siloed care that could be done more effectively through public health interventions

Societal cost (high)
Unending preventive interventions added for the team without subtracting others
Potentially limitless increase in overall primary care staff

E. Prioritise symptoms and illness

In order to sufficiently care for patients who are sick or have chronic symptomatic conditions, preventive care for low risk populations would be transferred from primary care to public health

Intended outcome

Patients who are sick or have chronic symptomatic conditions are seen by their own GP in a timely manner and receive appropriate care

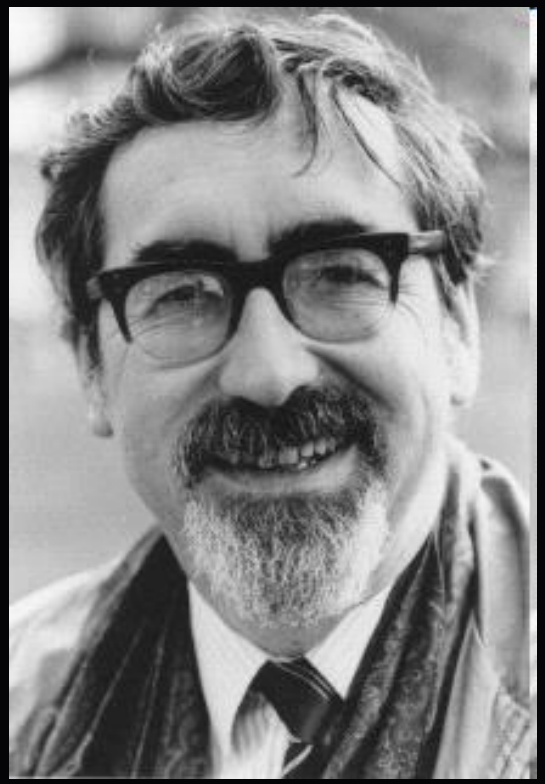
Actual outcome

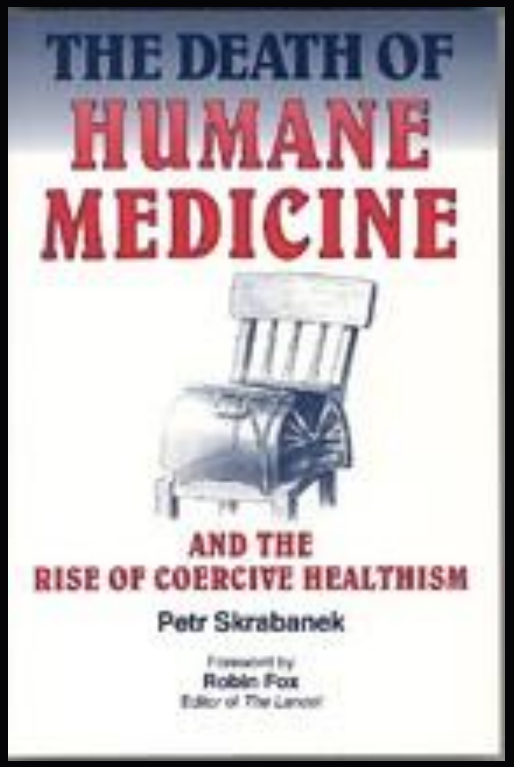
Patient satisfaction (high)
Timely and accessible medical care for patients who are sick or have chronic symptomatic conditions
Relational continuity improves - a cornerstone of effective primary care

GP satisfaction (high)
Able to assess and diagnose patients who are sick or have chronic symptomatic conditions
Provide care with strong evidence of benefit

Societal cost (net improvement)
Improved health outcomes
Improved equity
Fewer emergency department visits and hospital admissions
Public health is far more cost effective preventing disease in large low risk populations

Somos normales porque no nos hacen suficientes pruebas





Más atención sanitaria vinculada a más salud y mejores vidas

- Solo 3% de recomendaciones NICE sobre cambios de estilo de vida están sustentadas en evidencias moderadas o altas

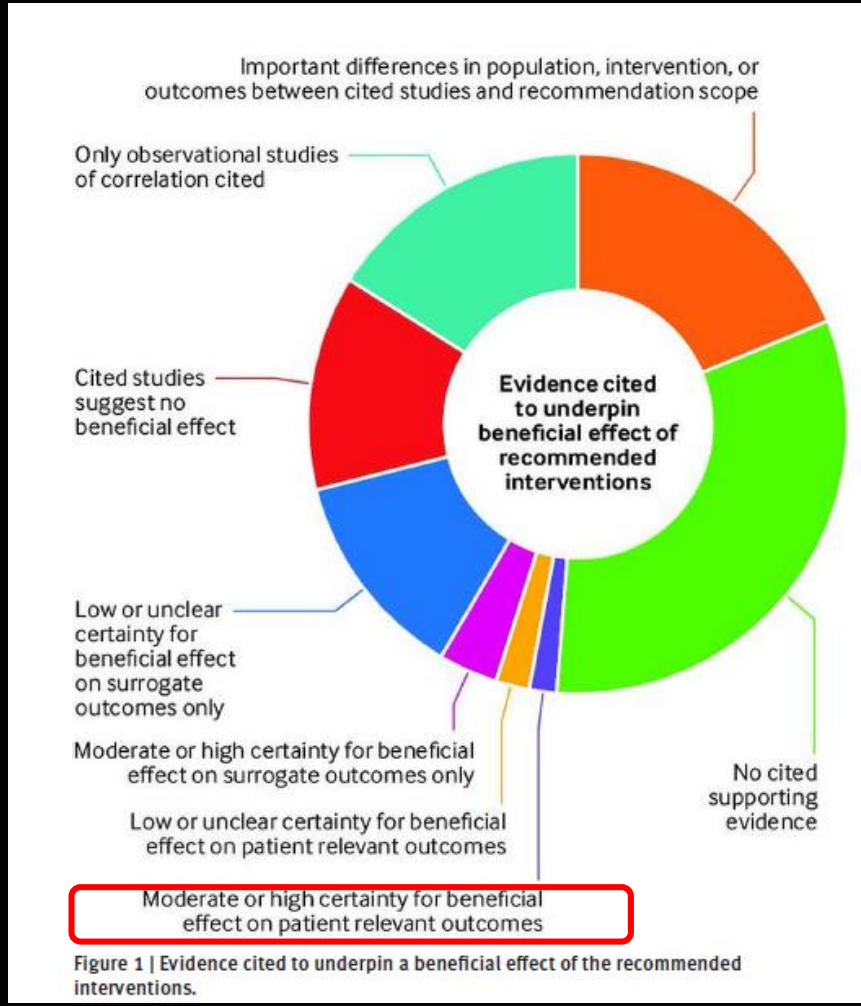
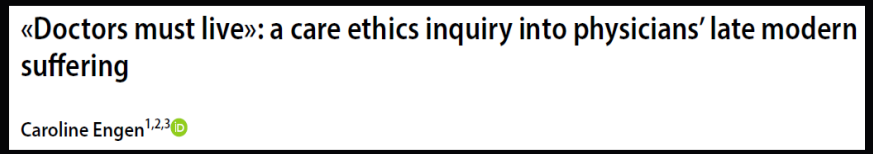


Figure 1 | Evidence cited to underpin a beneficial effect of the recommended interventions.

Albarqouni L, Ringsten M, Montori V, Jørgensen KJ, Bulbeck H, Johansson M. Evaluation of evidence supporting NICE recommendations to change people's lifestyle in clinical practice: cross sectional survey.BMJ Med 2022;1:e000130. doi: 10.1136/bmjmed-2022-000130 pmid: 36936567

Rethinking
(Pensar de nuevo)

- Mientras que previamente se integraba profundamente la identidad profesional en su estilo de vida, los médicos más jóvenes tienden a ver su trabajo simplemente como un empleo (Hertzberg 2016).
- La transición de la medicina a la ingeniería: los médicos se están reinventando cada vez más alejados de la presión de la atención médica: un sistema donde los profesionales de la salud son técnicos altamente cualificados y especializados al servicio del big data y los procesos automatizados de toma de decisiones sin atención directa a pacientes.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Caroline Engen[1,2,3]

¿Futuro?

- Fascinación tecnológica
- Liquidez
- Olvido
- Sistematización
- Incremento de producción

¿Pasado?

- Escuchar/tocar/esperar
- Permanencia
- Recuerdo
- Incertidumbre
- Prudencia en el consumo

A robot conducts the Orchestra Filarmonica di Lucca at Teatro Verdi in Pisa, Italy, this September.

Reboot for the AI revolution

As artificial intelligence puts many out of work, we must forge new economic, social and educational systems, argues Yuval Noah Harari.

The ongoing artificial-intelligence revolution will change almost every line of work, creating enormous social and economic opportunities — and challenges. Some believe that intelligent computers will push humans out of the job market and create a new 'useless class'; others maintain that automation will generate a wide range of new human jobs and greater prosperity for all. Almost everybody agrees that we should take action to prevent the worst-case scenarios.

The automation revolution is emerging from the confluence of two scientific tidal waves. Computer scientists are developing artificial intelligence (AI) algorithms that can learn, analyse massive amounts of data and recognize patterns with superhuman efficiency. At the same time, biologists and social scientists are deciphering human emotions,

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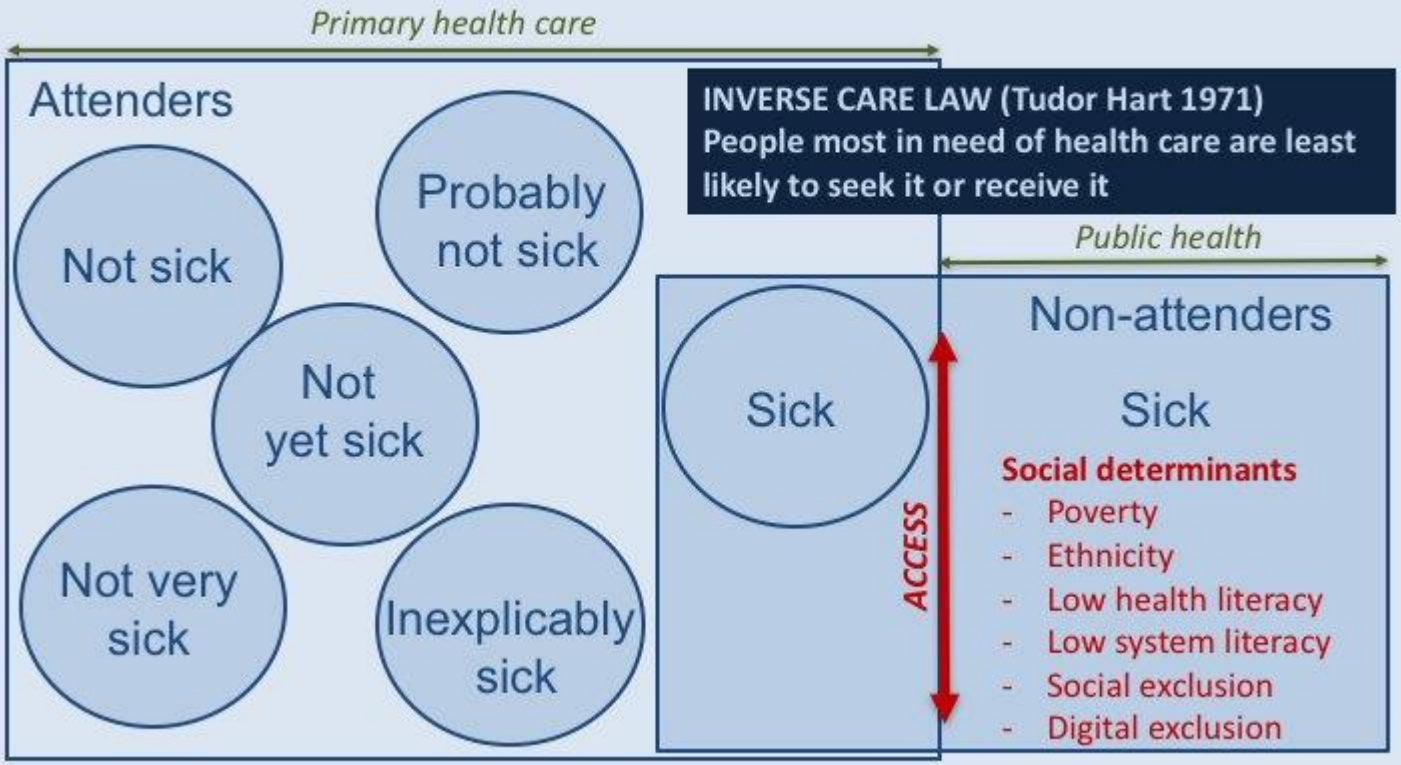
THE ECONOMICS OF ARTIFICIAL INTELLIGENCE

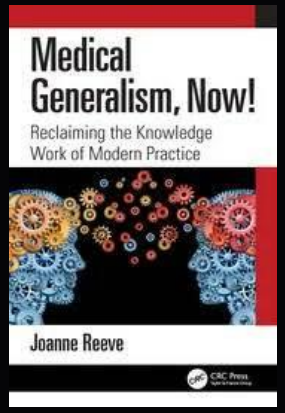
Health Care Challenges

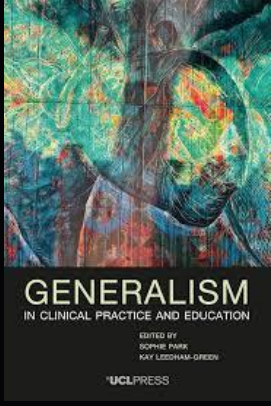
Edited by Ajay Agrawal, Joshua Gans, Avi Goldfarb, and Catherine E. Tucker

The inherently fuzzy caseload of primary health care



based on Ian McWhinney Family Practice 1983; 1:3-8

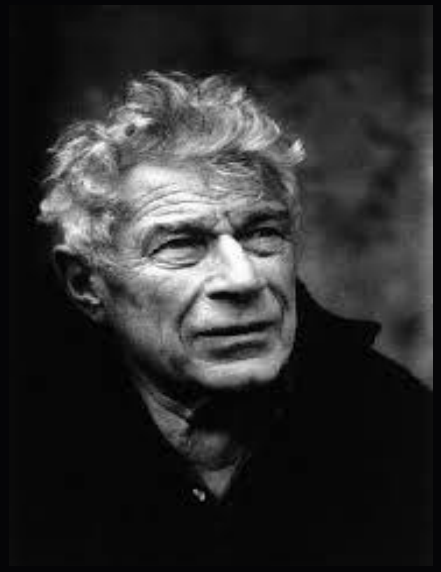




La práctica médica generalista se basa en un enfoque «exploratorio» centrado en la persona.
El objetivo principal de la atención centrada en la persona es mantener, restablecer o mejorar la capacidad del individuo para enfrentarse en condiciones a la vida diaria.

Los médicos generalistas utilizan el razonamiento inductivo para generar, a partir de un conjunto de datos, una explicación individualizada de la enfermedad.
La pregunta clínica subyacente es: «¿Debo diagnosticar a esta persona de la enfermedad o factor de riesgo X? ¿Mejorará la capacidad para enfrentarse a la vida diaria de esta persona etiquetarla con este diagnóstico?

Joanne Reeves, BJGP,2018



“ Sassall nunca separa una enfermedad de la personalidad general del paciente que la sufre: en este sentido es lo opuesto a un especialista. No cree en la necesidad de mantener una distancia imaginaria: ha de acercarse lo suficiente para reconocer al paciente en todo su ser. Aunque tiene unos dos mil pacientes es consciente hasta que punto están todos relacionados, de modo que los número casi nunca adquieren para él una objetividad estadística”

A manera de resumen

- Longitudinalidad como eje
- Persona + población= AP + Salud Pública
- Ampliar perfiles con tiento y evaluación
- Universidad: un cambio utópico
- Cambio de la relación laboral
- Diferenciación con el especialista prestigiando el generalismo
- Cambio de relación laboral
- Abordaje contra la medicalización
- Presión y lucha